THE

TIMES AND REGISTER.

A Weekly Journal of Medicine and Surgery.

Published under the auspices of the American Medical Press Association.

WILLIAM F. WAUGH, A.M., M.D., Managing Editor.

Vol. XXIII. No. 18. Whole No. 686. } NEW YORK AND PHILADELPHIA, OCTOBER 31, 1891. { Yearly Subscription $5.00, in advance. Single Numbers 10 cents.

Published by the Medical Press Company, Limited, 1725 Arch Street, Philadelphia, Pa.

Agents in Paris: E. Besinee, 19 Rue Vaneau. Entered at the Philadelphia Post Office as second-class mail matter.

Notes and Items.

THE works of watches are now plated with palladium, which is a whiter, lighter and more fusible metal than platinum. About one-seventeenth of a grain of palladium will, by electrical deposition, coat the works of an ordinary watch.

AHA! I catch you buying a porous plaster, do I? I thought your devotion to fresh-air theories would bring you to this?

"It ain't the plaster that does me good," answered the crank; it is the ventilation obtained through the holes.—*Indianapolis Journal.*

THE SIDE TO SLEEP ON.—"Which side should I sleep on doctor?" he inquired.

"In winter or summer?" asked the doctor, rubbing his chin thoughtfully.

"What's that got to do with it?" exclaimed the patient, half angrily.

"A great deal," responded the doctor, mysteriously.

"I don't see it."

"Of course you don't" said the imperturbable; "if you did you wouldn't be here asking me about it."

"Go ahead, then," said the patient, sitting back resignedly.

"Well," continued the doctor, "in winter, when it is cold you should sleep on the inside; but such weather as this, you should sleep on the outside, in a hammock with a draft all around it, and a piece of ice for a pillow. Two dollars, please."—*Detroit Free Press.*

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REGULAR SESSION OF 1890-91, OPENED SEPTEMBER 15, 1890.

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The Times and Register.

Vol. XXIII, No. 18. NEW YORK AND PHILADELPHIA, OCTOBER 31, 1891. Whole No. 686.

Clinical Lecture.

CHRONIC RHEUMATISM.

By JAMES M. ANDERS, M.D.,

Professor of Theory and Practice of Medicine, Clinical Medicine and Hygiene at the Medico-Chirurgical College of Philadelphia.

GENTLEMEN:—I want to show you to-day this young girl, aged sixteen years, with a negative family history, who ten years ago had an attack of rheumatism when she also had an inflammation of the eye, which brought on a cataract. Since then she was free from rheumatism until after she moved from the country to Philadelphia, about one year ago. Not long after removing to Philadelphia, she began again with rheumatism, which was first felt only in the smaller joints of both hands and both feet, all the joints being affected almost simultaneously. At first the joints were tender to the touch, painful more especially at night, somewhat swollen, and, perhaps, very little reddened. There was little or no fever present, and I may have stated that is one of the distinguishing characteristics of chronic rheumatism, which frequently follows acute rheumatism, though sometimes years later. Now she also tells us that during the last eleven months she has had exacerbations several times, with the symptoms named, and at other times was comparatively free from them. That is also very characteristic of the course of chronic rheumatism. The disease is very much influenced by weather changes and by locality of residence. She lives, she thinks, in a comparatively dry home; but the fact that she began with rheumatic symptoms as soon as she removed to Philadelphia, and had not had rheumatism for ten years prior, goes to show that, after all, the house to which she removed may not have been so dry as it should have been, and, hence, may have caused rheumatism. For we do know that damp residences are frequently the cause of chronic rheumatism, as well as a leading factor in the causation of acute rheumatism.

It is a very important matter to decide as to whether you have a case of chronic rheumatism or a case of gout to deal with, and, then again, it is important to distinguished chronic rheumatism from so-called rheumatoid arthritis, which is not rheumatism at all, though an affection of the joints.

Rheumatoid arthritis is apt to occur later in life, and is a steadily progressive condition, one joint after another becoming implicated, without any decided subsidence in the local symptoms of a joint once affected. Cases of rheumatoid arthritis also result, by and by, in ankylosis of the joint, and there is greater deformity than we see here. The ends of the bones become enlarged and very much thickened, while the soft structures near the joint waste very much in rheumatoid arthritis; hence, the well-marked deformity that is almost universally present. Later, there is ossification of the soft structures around the joint, with complete ankylosis, and it is by this condition that you will often be obliged to distinguish between cases of rheumatoid arthritis and cases of chronic rheumatism. Partial ankylosis rarely occurs in far advanced cases of chronic rheumatism; they do have impairment of motion. You may find only limited motion in the joint; decided stiffness, with persistent enlargement; but you never have in chronic rheumatism, however far advanced, complete ankylosis.

You have now to distinguish from chronic gout, not always an easy matter. Gout is markedly hereditary; rheumatism is also hereditary, but not quite to the same degree. In rheumatism, you will generally have a history of exposure in a damp residence, as in this girl's case, or exposure out of doors to wet and cold. Not so in cases of gout. You, however, often get a marked history of over-feeding prior to an attack of gout. The attack of gout comes on at night, and, as a rule, affects the toes and smaller

joints. No such history was obtained from this patient. These paroxysms last a much shorter time than an attack of rheumatism, either acute or chronic; you have, in gout, deformity and stiffness on account of the deposits of urates in the joints. In gout, you have the urine much more implicated than in chronic rheumatism, and so also is the blood. If you are in doubt as to whether a case is one of gout or chronic rheumatism, examine the blood under a microscope for uric acid crystals; if you find these, you may be sure you have gout to deal with. This never occurs in cases of typical rheumatism, but does usually occur in gout. Uric acid crystals in the urine are pathognomonic of gout.

Much more might be said as to these diseases; I have given you only the leading points in the differentiation. The history is of course different in different instances. The history of this patient's case also points clearly to rheumatism. Since this girl came here in June she has improved. Her treatment has been the administration of four lemons daily, a teaspoonful of Rochelle salts once a day, and a tonic mixture consisting chiefly of tincture of calumba, before each meal. In cases of rheumatism, we attempt to maintain an alkaline condition of the blood, and we know, as physiologists, that the vegetable acids are the natural means for maintaining this alkalinity, so that the administration of lemon juice is a perfectly rational method of treatment. Besides this, we find that the so-called anti-rheumatic treatment in cases of chronic rheumatism, has really very little beneficial effect; far better is it to improve the nutrition of the patient; far better is it to give tonics, more particularly the bitter tonic. Additionally we may administer cod-liver oil. I think there is no better remedy in chronic rheumatism than cod-liver oil given continuously, provided that the digestive organs will tolerate it. When anæmia is present, we administer iron; a little iron would do this girl no harm, as she has some of the evidences of anæmia, viz.: pallor of the skin and mucous membranes; but since she has improved under the present plan of treatment, we will continue it until Professor Woodbury, whose patient she is, returns.

Original Articles.

OBSTRUCTION OF THE BOWEL.[1]

By M. PRICE, M.D.

THE treatment of obstruction of the bowel is one of the greatest importance to the public as well as the profession. There is no subject or condition where life so positively depends upon a proper appreciation of the conditions and immediate and correctly applied surgical treatment.

There is no condition where the complications are so varied, from simple hernia to virulent malignancy; there are so many conditions that will produce obstruction, that the wonder is that any of us get through life with a complete and healthy bowel in our body.

The causes of obstruction are almost innumerable, and every case is one to be dealt with in a manner peculiar to itself. The life of the patient depends upon the ability of the operator to cope with the complications, more than any other factor.

To appreciate the difficulties to be overcome in this department of abdominal surgery, one has but to examine the work of Senn and a host of others who have done work in the abdomen, and ask any one of them what part, if any, is easy of accomplishment.

In most cases of obstruction of the bowel there is no indication or symptom to indicate or direct us to the point of obstruction.

We have a patient with an enormously distended abdomen with symptoms of peritonitis, with fecal vomiting, with pulse and temperature to indicate a condition of things for most urgent and prompt action. Or we may have an obstruction with scarce one of these symptoms to direct us in our investigation. Help can only come to a patient suffering thus from one who can correctly read the symptoms and correctly interpret their magnitude. Abdominal surgery for many years offered hope of relief to a very small number of abdominal diseases, but now surgery has thrown open the door to all who suffer with abdominal disease with the same opportunity for relief that the surgeons offered only a short time ago for ovarian tumors, with a vastly improved method and a greatly reduced death-rate.

In obstruction of the bowel there are so many questions and conditions to be considered before operation, that when the time comes to operate, it is very much like a well-planned battlefield with every division in position and all the minor details settled; the work of battle begins, and the surgeon only waits the development of the enemy or disease with which he has to contend in the completion of his work in the removal of the conditions present.

The first question to be decided is: Is there a strangulation present, or an obstruction, or a condition of partial paralysis induced by over-distension, by a costive habit, or a condition produced from loss of proper nerve force for the performance of bowel digestion and elimination, or is it a paralysis following convulsion with general paralysis of the entire body? All these questions have to be answered some time in the experience of every operator, not all in the same case, but they all have a place in the consideration of the question in hand, and the operator who does not keep his mind impressed with such possibilities, will sooner or later have cause to regret.

There is no better place than just here to relate a case in point. Dr. Ewing, of West Grove, asked me to see a patient with symptoms of obstruction of the bowel, in a woman sixty-five years old, who had been suffering for five days from great distention, the bowel showing through the abdominal wall very much like a mass of sausage under a linen cloth, an increased pulse and a temperature something above the normal, but not enough to indicate a serious condition. The other symptoms indicated an element in her condition that led me to investigate further for a cause. The doctor had used all the agents, purgative and otherwise, without effect; the stomach now refused all drugs. The daughter stated that the patient had a convulsion two nights in succession before the doctor had been called to the case, and that she had been quite stupid and unlike her usual self since that time. The knuckles of intestine lay without a particle of movement, no peristalsis; in fact, there is a condition of paralysis following a convulsion that so closely simulates obstruction, that it is with great difficulty that we come to a proper appreciation of the symptoms. This patient had also vomited very questionable matter, and together with the other symptoms seemed a plain case for operative treatment; but there was a question of doubt, and after waiting a period, the sulphate of magnesia in large and repeated

[1] Read at the Philadelphia County Medical Society, October 14, 1891. For Discussion, see page 356.

doses by injection, brought the result, clearly showing that we must be on our guard with every case.

The stomach exercises a marked influence in obstruction of the bowel; the changed current and direction of the bowel contents, in its effort to find an exit, changes the stomach from an organ for the digestion of food to that of a pump for the elimination of the contents of the bowel through the mouth, and by so doing gives us a direct and positive indication for treatment, which to be most effective must precede any operative treatment that may be required.

We should empty the stomach and wash out all the contained fluid and solid contents. How best to do this is a question by no means yet answered. For my part I much prefer the stomach, aided by warm water and a mild emetic, to do the work, when the patient is in a condition to warrant such an effort, but many of them will not; then only the pump must be used. It is a most disagreeable instrument and should be used with great care, and not removed until all the work of flushing the stomach is finished. If you operate for strangulated hernia after there has been fecal vomiting, and leave the stomach to get rid of its disagreeable contents as best it can, you have but half done your work, and more than probable the portion left undone will finish your patient.

In a complete cleaning out of the stomach you have added greatly to your patient's comfort, and to his immediate and rapid recovery; beside having left nothing in the way of a clear surgical conscience. Therefore a stomach-pump is requisite to perfect work in obstruction.

Treatment.—The saline treatment of complicated inflammatory conditions, and those simulating inflammatory obstruction of the bowel, are of twofold value; first in clearing out a bowel not obstructed, but torpid and distended with all the filth of months; again, in actual obstruction, where we have a condition of paralysis produced by the inflammatory condition, which can best be removed by sulphate of magnesia. The effect of the saline does not in the least hinder the operative treatment, but prepares the patient for a much more speedy recovery from the effects of the inflammatory condition and the operation for the removal of the cause of the obstruction. If the obstruction be purely mechanical, then the saline aids the efforts of nature to promptly throw off all the retained and decomposing materials remaining dammed up in the intestine by the obstruction.

After an obstruction of the bowel has existed, even for only a short time, the distension has in most cases been so great that it takes a long time for the bowel to recover its tone and normal function, and if the saline treatment has been used before the operation the time for recovery will be much shortened and the risk and suffering of the patient correspondingly lessened. All those who have done intestinal work have been impressed with the length of time after an operation for strangulated hernia before any action of the bowels can be had, even with salines. I have had as much as six and eight days pass before I could get the bowels moving in cases of obstruction of the bowel from inflammatory incarceration. And in another case as much as eleven days intervened after a resection of five inches of obstructed colon from epithelioma and uniting them by the Senn method. In this case four ounces of magnesia sulphate was given before any result. In several of my cases I feared that I would have to do them over; and I have no doubt the abdomen has been reopened many times after abdominal operations for a supposed obstruction, when none existed. So great care and judgment is required in these cases, that something positive only should drive us to a second operation. Simple want of a movement of the bowels should put us on our guard and watchful for more certain symptoms of obstruction.

Now as to how sulphate of magnesia will give the best and quickest result: Small and repeated doses diluted with as much water as the patient will take is by all odds the best mode of giving the drug. When the stomach is irritable and sick, it is best given by injection per rectum—an ounce of the drug in half a pint of warm water. If you can give by the stomach and bowel at the same time, you will soon get the result.

There can be no objection to other drugs being used, such as the mild chloride of mercury, Rochelle salts, that will accomplish the object for which we use purgative treatment. Mixed treatment of opium and purgatives does no good, but introduces an element of doubt and danger that is hard to estimate; it also tends to prevent a proper appreciation of what nature is doing to save the internal viscera from permanent destruction and death. If we give purgatives we must give them for a purpose, and until that object is attained we should wait until we are perfectly satisfied that nothing but an operation will open the way for a passage, or that our patient cannot be relieved, and then the opium treatment will be appropriate; then use it, but not while there is a chance for the patient's recovery.

Mode of Operating.—The method of operating for strangulation of the bowel or hernia is of great importance, and should be seriously considered before operation. The method of cutting directly down on the hernia will not answer in all cases; old irreducible hernias, where both sides are down and irreducible with symptoms of obstruction; double femoral, also irreducible, and in cases where there are no external symptoms pointing to the location of the disease—these can best be dealt with through a median incision.

The usual opening for abdominal operations of one and a half inches is plenty of room in which to do all the work that is required for the relief of the patient in most cases, and when we find we require more room, it is easy to enlarge the incision. Through this opening a thorough investigation of the abdominal cavity can be made, the old hernia irreducible protrusions can be examined with two fingers in the peritoneal cavity, and the seat of the strangulation located.

The fact that there is a hernial protrusion on either side is no proof that one of them is the point of strangulation; it may be anywhere in the length of the intestine. Then, to open such a patient over the supposed point of strangulation would greatly complicate the case, and leave the surgeon in doubt as to whether his patient had been relieved of his strangulation, for often in operating for strangulated hernia, I have had the intestines slip from the sac into the peritoneal cavity, and it was considerable trouble to get hold of the portion strangulated so as to examine its condition before closing up the abdominal cavity. Until the point of strangulation is found and examined, you can never be sure your patient is relieved of his dangerous condition.

Then, again, there is no better way to ascertain which is the obstructed side save through a median incision, both sides being within easy reach, and can be examined and dealt with with certainty. When the position of the strangulation is determined, it is an easy matter to cut down and release the hernia

from its sac, and return it to the inside, and bring the intestine to the median opening, and there examine its condition, and if there is a show of returning life to the strangulated portion, then wash with warm water that has been boiled, and return to the peritoneal cavity with as little delay as possible. The closure of the wound is of moment, for on the manner of doing this depends the success of a radical cure of your patient.

Leaving the sac outside in position, and taking a long, straight needle, and with two fingers in the peritoneum, push the needle through the abdominal wall, taking care to include all of its wall, so that when it is closed there will be plenty of tissue; it does not require to be very tightly tied, but just sufficient to make a perfect approximation. Before making your closure, trim up your sac and remove all portions thickened and diseased that could interfere with perfect union of the hernial wound.

The inside fingers act as a guide to protect the bowels and to aid to a proper placing of the sutures, and as the sutures are being tied assure yourself that all is clear and a perfect closure made. This can be determined with perfect accuracy.

The gaseous distention of the abdomen is a most serious complication, and offers many impediments to a proper diagnosis; that it must be gotten rid of before the patient be relieved is admitted by all. Puncture through the abdominal wall with any instrument is dangerous in the extreme; to use a hypodermic needle would be a useless procedure, as much larger openings are required before the gas will be discharged. I have repeatedly tried to empty the bowel in this manner, and feel confident that it would require days to do so. An opening should be made with the knife or some instrument that will puncture the bowel, and the instrument then opened, stretching the bowel, giving exit to the gas. For this purpose I have had an instrument made almost identical in form with the little ear speculum, bringing the trumpet to a point, with which to make the puncture. The opening can then be stretched, and the closure will require only one stitch, while that made by a knife would necessitate several. I have used it only once. It answered the purpose admirably. As the needle rapidly enlarges from its point the bowel must be grasped by the fingers to prevent slipping while being dilated. Besides this advantage the instrument shortens the operation, lessens the shock, and prevents leakage. Comparing methods of treating obstruction of the bowel, there is but one treatment, that is to open the patient and correct the trouble—when I say that I do not mean that there shall be a half dozen consultations before this treatment is resorted to, and I will venture to say the mortality will be reduced from its present high figures to 15 per cent. Those credited cured by other methods in most instances were mistakes in diagnosis. No one was ever killed or their danger increased by an exploratory operation.

Much of the recent work done in abdominal surgery has been by men who base their opinions on experiments on dogs. This work accomplishes only one good—it prepares the surgeon with manipulative skill and dexterity in operating. But this experimental or dog surgery has not a single feature in common with that on the human subject, for there is no resemblance either in the operation or the conditions present. The one is on a healthy animal with an intestine only one-third the length of the human, and has been used for the passage of the coarsest food and the most indigestible materials.

With no nervous element to contend with, no pathological condition to contend with, no distention or delay, no previous shock or destruction of parts, no inflammatory element to remove, no complications to hinder or delay the operative work, no half-dozen consultations, no opium or belladonna previous to operative work—in fact, the one differs from the other as day differs from night. And it is these very conditions, and complications, and delays that make all the difference between life and death. Could we bring the profession to look at the conditions and dangers of peritonitis and obstruction of the bowel in its proper light, and have all such conditions treated at an early period, there would be some chance for the patient to recover from the mischief already done by the disease, for intra-peritoneal inflammatory conditions soon destroy life. The surgeon cannot do any harm nor add one feather's weight to the already dangerous condition, but with good work will save hundreds of valuable lives. Senn's experimental work on dogs was for a definite purpose, which he has beautifully set forth in his book, and clearly demonstrated to us all, and those of us who work in this field can only hope to be imitators of him.

Dr. Theodore McGraw, of Detroit, gives us a most ingenious method of managing some of the more desperate cases of intestinal obstruction. In complete gangrene of the bowel I imagine it will be of great service in saving life. In these cases we are compelled to make an artificial anus; which will relieve the urgent symptoms of distension, while, at the same time, the rubber ligature recommended by Dr. McGraw passed through two or three inches below the artificial anus, through the upper and lower segments of intestine, including at least one and a half inches, and tied as tightly as possible, and the knot secured by ligature; then either a continuous or interrupted Lembert suture around this ligatured portion, and, by the time the ligature has cut its way through, the union will be complete, without any possibility of leakage, and with but little delay or prolongation of the operation.

Complete exit will be given through the artificial anus to all distending gases and contents of the bowel, until the artificial opening is complete (which is three or four days), when the artificial anus can be closed by silkworm-gut sutures placed at the time of operation. This method also comes to our relief in obstruction of the gall-duct. In these cases the abdomen is opened, the gall-bladder emptied of its contents, the rubber ligature used to unite the intestine to the gall-bladder, the additional suturing of the peritoneal covering of the bowel and gall-bladder, so as to insure perfect union, and in three or four days the abdominal wound can be closed with silkworm-gut sutures; the fistulous opening between the gall-bladder and bowel—made by the rubber ligature—will prevent many of the annoyances and inconveniences of having a biliary fistula.

It will in many ways answer a better purpose than the Senn method, but in the vast majority of cases Dr. Senn's method of anastomosis is our only one to save life; we cannot wait two or three days for an opening to be made; therefore, of necessity, we must resort to the method of Senn.

I have used Dr. Senn's method three times, with two recoveries, and must say I have more admiration for him and his work than any intestinal surgeon in the world.

I have found, in using the Senn plate or the Abbe catgut ring for intestinal anastomosis, that one of the greatest difficulties to overcome was the passing of

the silk ligatures through the intestine, there being four or six of them in each plate or ring. When they were threaded in the ordinary sewing needle they became entangled and greatly prolonged the operation, or, if they had to be threaded during the operation, it was the cause of considerable delay, and for a long time I have been trying to find a substitute that would answer the purpose without any of the objectionable delays. I have found the desired needle in the self-threading Supplee sewing-machine needle. In the use of this needle the operation is shortened at least four-fifths, all the threads being passed rapidly and without delay.

The ring or plate placed in position, the operator holds the needle with the open face of the eye toward him, the assistant takes up the ligature, draws it taut at right angles to the needle over the eye, and it is at once threaded. The operator quickly passes it through the intestine, half an inch from its cut border, and the assistant withdraws the ligature from the eye. The same process is gone through with all the sutures, and it is done in a moment, without delay.

"Ashhurst tabulated 57 cases of laparotomy for acute intestinal obstruction from other causes than intussusception, from which it will be seen that only 18 terminated favorably. At that time the mortality of laparotomy in cases of intestinal obstruction other than intussusception was over 68 per cent. Most of these operations were *performed without antiseptic precaution.*"—*Senn*, page 28.

I have had a greater number recover from this operation, and have operated for obstruction only 24 times, and always without antiseptic dangers; only clean Philadelphia water; 19 recovered.

Dr. Ward, of Topeka, Kansas, recommends a most ingenious method for finding the proximal and distal ends of the intestine. Pass the fingers directly down to the attachment of the mesentery to the spine, and the position of the two ends will be immediately established, as the lower attachment of the mesentery must of necessity belong to the lower end of the bowel.

GUNSHOT WOUND, WITH USE OF THE ELECTRIC PROBE.[1]

By A. B. KIRKPATRICK, M.D.

MR. S. came to my office Friday, 3 A. M., October 2. He was stage manager for the Grand Opera Company, and is now dramatic teacher at Penn Conservatory of Music. He returned from the theatre after attending to some business after the performance, and happened to think of a loaded revolver, and thought best to remove the cartridges, and believed he had removed the last one when his wife spoke to him, and his attention was drawn from the revolver a moment, and in that instant it went off, and he received the bullet, thirty-two caliber, in the leg above the knee. The muzzle of the revolver was not more than six inches distant, and the trouser leg was blackened and scorched.

Mrs. S. urged him to go at once to the doctor, and supported and assisted him to walk the three squares, and he was nearly exhausted by the time he reached my residence.

I gave him a stimulant and probed for the bullet, and thought I located it just above the patella on inner condyle of the left femur. The probing was very painful, and I was unable to get hold of the ball with the forceps, and I did not care to give an anæsthetic and go on with the operation without assistance, so I put him to bed and gave him a hypodermic of morphine and atropine, and he slept until 8 A. M.

I sent for Drs. W. H. and C. B. Warder, and for an electric bullet-probe, which I had seen a day or two before. At 11 A. M. the doctors came, and Mr. Yarnall sent a man with the probe. Dr. Warder, Jr., etherized the patient, and Dr. Warder, Sr., enlarged wound and searched for the bullet carefully. He found a rough spot on the condyle, where apparently the bullet had struck and roughened the bone, and then been deflected and passed into the popliteal region, as the course of the bullet had been downward, forward and outward.

Mr. S. is a bicyclist, and has a fine muscular development—the wound being over two and one-half inches deep. We were about giving up the search when I felt what was apparently a spicula of bone, and to determine the fact passed the electric probe down along my finger, and with considerable difficulty placed it on the rough point. The alarm sounded, and we were convinced that the point was a corner of the bullet. I enlarged the wound and found it so. The bullet was buried in the bone, and the periosteum had closed over it, except a little corner as large as a pin-head, which had been turned up by the bone. We were not supplied with bone-chisel, or gouge, and the bullet was below the surface of the bone, so forceps were of no use. I drew on the family tool-chest for a gouge and the kitchen for the potato-masher, which I used as a mallet, and chiseled the bone away on one side so that I could pry the bullet out. We syringed out the wound with bichloride solution, 1 to 4 000, and Dr. Warder put in the sutures and a gum drainage tube, and covered the wound with iodoform gauze, and placed it in an improvised splint of trunk board.

The operation was long and tedious, and the patient did not regain consciousness until 3 P. M. He was too weak to remove from operating-chair until 9 P. M., at which time he walked to the next room on crutches and went to bed.

In June he had suffered from functional disturbance of the heart from excessive smoking. He did not react well after the operation, and the heart was weak and irregular, so I gave hypodermics of strychnine and atropine, and inhalation of ammonia, and used hot-water bags. There was no vomiting. He had a temperature of 101° the evening of the operation and 102° next day. The third day 101°, and the fourth day normal. He required no anodyne whatever. The day after the operation I gave calomel, ipecac, and soda, followed by a Seidlitz powder, which moved the bowels freely. I also gave a five-grain powder of phenacetine every two hours until the temperature fell to normal.

The day after the operation I looked at the drainage tube, and applied fresh gauze, and the second day syringed out the wound with bichloride solution, 1 to 4,000. The morning of the fifth day the stitches were removed, and their place supplied by narrow strips of plaster. The patient sat up the sixth day, and I took him home the seventh day, and he has been walking around on crutches since. Yesterday was the eleventh day, and he was at a rehearsal, and expects to begin his usual work to-morrow evening. He kindly offered to come here to-night, and Mr. Yarnall is with us to exhibit the electric probe.

[1] Read at the Philadelphia County Medical Society, October 14, 1891.

AN INSTRUMENT FOR MAKING APPLICATION TO THE UTERINE AND URETHRAL CANALS.[1]

By A. B. KIRKPATRICK, M.D.

FOR the past three years I have been working in the Philadelphia Medical Mission, and it has been necessary for me to do considerable gynecological and venereal work, minor operations for misplacements, endocervicitis, endometritis, lacerations, etc.

I have been experimenting to find a rapid, cleanly, and economical way of making applications to the endometrium and urethra.

I have used suppositories, tampons, and medicated bougies, only to be disappointed. To my mind the excipient in medicated bougies and suppositories prevents the absorption of the medicament by coating the passage, and when the suppository or bougie liquefies, by the heat of the body, the medicament is drained away from the location where placed and needed.

I began the use of powder by insufflation to the cervix and vagina several years ago, and for ulcerated conditions of cervix it gives excellent results.

My first instrument, which I made myself over a year ago, was a hard rubber insufflator tube with a wire wrapped on the extremity with thread. With this crude instrument I could push powder, boracic acid, iodoform, aristol, etc., into the cervical canal or urethra. At my request last April, Mr. Yarnall made me this instrument, which originally had a copper wire for piston, tipped and packed like a hypodermic syringe piston, and in place of the finger pieces, a half-inch hard-rubber collar. The copper wire bent and stretched on straightening and the leather packing was not clean or aseptic.

This improved applicator is made of a seamless aluminum tube with a steel piston aluminum-pointed and steel finger and thumb pieces. It is very simple in construction and is easily used.

Society Notes.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, October 14, 1891.

The President, JOHN B. ROBERTS, M. D., in the Chair.

OBSTRUCTION OF THE BOWEL,[2]

WAS the title of a paper read by Dr. M. Price.

DISCUSSION.

DR. JOSEPH PRICE: As I am quite familiar with what the author has said and done, I shall have little to say about the paper. The old classification of acute and chronic obstruction is quite sufficient for surgical purposes. I wish simply to call attention to a few points derived from my clinical experience: First, in regard to the casual relations which surgery bears to some forms of obstruction. The author has alluded to the reduction of hernia without the relief of the inflammatory adhesions causing strangulation. Only a short time ago some one presented to the Pathological Society a reduced strangulated hernia. It was fortunate for surgery that in that particular case a post-mortem was secured. I am satisfied that if more examinations were made in the fatal cases of hernia operation, reduced strangulations would be found frequently. My own practice is to open the sac and deliver the bowel and free it from all strangulating bands. If you simply sever the stricture either by the old or new method, and do not draw the bowel out completely, you will fail to recognize the construction that commonly exists about its neck. I would make it an inflexible rule to expose the bowel in all hernia operations.

Again, those forms of acute strangulation due to bands about the appendix and the pedicle of removed cystoma, which in many cases are sequellæ of appendicitis or pelvic inflammatory trouble, and are not a very small or simple class of cases. Only two days ago I attempted to remove an abscess of the right ovary and tube, and found overlying and fixed to these pus accumulations all the ileum that could get into the pelvic cavity. I found complete strangulation of at least four inches of the ileum and perforation at two points—I mean complete as we commonly understand such strangulation from inflammatory thickening and kinking with fixation. In removing the bowel I laid open two cheesy portions of the bowel, necessitating anastomosis and resection. It is in this class of cases that we lose our patients unless we complete the enucleation of such thickened and adherent bowel. The neglect of this is a common cause of death in pelvic inflammatory troubles. On two occasions I have had to reproach myself, notwithstanding I knew at the time of the sections, which were difficult and complicated, that I had not completed my work to my own satisfaction. In a few days I had cause to re-open both of these cases. I have now a patient in bed after the removal of the fused viscera of the pelvis, and I spent probably half an hour in the removal of the strangulated and adherent bowel. It was fused to that extent that it was impossible to see the mesentery on either side before freeing the adhesions.

Another class of cases is of interest in this connection because we have had so many new methods proposed for their relief. One of these methods, proposed by the Germans, is by removal of the coccyx and going in posteriorly and removing the pelvic mischief. Such a method must always result in the neglect or non-recognition and relief of bowel complications above. The same serious objection applies to the recent French method of dealing with pelvic inflammatory troubles by the vaginal method of extirpation of pelvic viscera. If by this method we could deal with bowel adhesions I would welcome it, for in many forms of tubal and ovarian trouble we leave behind a great deal of filth when we permit the uterus to remain. Dr. Coe has reported ten cases of vaginal hysterectomy, two of which died of strangulation, I think in a short time after the operation. It is not improbable that in these cases tubal and ovarian disease with adhesions existed, and that in the removal of the uterus the effect of these adhesions was increased. In a case yesterday where I removed the uterus for cancer, I found double hydrosalpinx with bowel adhesions. In this case I operated by the vaginal method and brought the bowel to the vaginal orifice to free it. If in this case there develops the slightest indications of bowel adhesions, I shall operate at once. Again, there is a group of cases—obstructions due to bands of adhesions following the use of chemical solutions in abdominal operations.

[1] Read at the Philadelphia County Medical Society, October 14, 1891. For Discussion, see page 357.

[2] See page 352.

AN INSTRUMENT FOR MAKING APPLICATION TO THE UTERINE AND URETHRAL CANALS,[1]

Was the title of a paper by A. B. KIRKPATRICK, M.D.

DR. JOHN C. DA COSTA: The powder applicator presented shows how different people may arrive at the same conclusions without ever discussing the matter with each other. It is a capital little arrangement, but I have one that is precisely similar in principle, given to me some ten years ago by Dr. Ellerslie Wallace. One of his favorite applications to the endometrium was powdered sulphate of zinc, which he applied with the instrument. One reason why we often fail to get good results from ointments is that the uterine canal is sometimes covered with a glairy deposit of mucus. Before an ointment can come in contact with the membrane this mucus must be removed. A powder may act differently, for it is retained, and if soluble, will gradually melt and pass through the mucus.

DR. C. P. NOBLE: I wish to make a few remarks bearing on the general principle of the application of medicaments inside of the uterus. My own experience has led me to the conclusion to which the attention of the profession was called by Dr. Emmet, that applications inside of the uterus are very seldom indicated, and that their field of usefulness is extremely restricted. I think that Dr. Emmet and his co-laborers have shown that the majority of cases of discharge from the uterus are not caused by inflammatory trouble inside of the uterus, but by disease outside of that organ, and, therefore, it is illogical to make applications to the interior of the uterus in the class of cases under consideration. The treatment of the causative lesions in these cases is much more satisfactory, less painful, and free from certain dangers which attach to applications to the endometrium—including uterine colic, and salpingo-peritonitis. I am, however, quite satisfied that there are cases in which it is proper to make applications inside of the uterus, as, for instance, cases of purulent endometritis, due to gonorrhœa, for example. In fungous endometritis, where the condition is not sufficiently marked to require the curette, applications to the endometrium are useful and will often effect a cure. In the condition formerly called endometritis, the evidence of which was uterine discharge, I take it that treatment of the endometrium is not indicated, and is harmful rather than beneficial.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

Stated Meeting Held Thursday, June 11, 1891.

THE 728th regular meeting of the Society was called to order by the First Vice-President, DR. F. C. BRESSLER.

Minutes of previous meeting read and approved.

The following gentlemen were elected to membership: Dr. W. B. Perry, Dr. O. S. Mahon, Dr. E. B. Fenby, Dr. Arthur H. Mann, Jr., Dr. Chas. M. Morfit, Dr. D. V. Moyer, Dr. F. Dyer Sanger.

DR. DAVID STREETT related a case of Ante-partum Hemorrhage. Mrs. V., aged thirty; pregnant for the fifth time in seven years, healthy in appearance and at about the end of seventh month of utero-gestation. Her previous four confinements were of short duration and perfectly normal.

Was called to see her on June 10, about 12 P. M., and learned that she had been active as usual about her household duties, and that about 10 A. M., while out walking, mild labor pains came on and continued, very moderately, until late in the evening, when they disappeared.

She retired at 10 P. M., feeling quite well, and at 11.30 was awakened by what she thought was urine flowing from the vulva. On lighting the gas, she discovered her clothing and bedding stained with blood; feeling a desire to urinate, she discovered, on rising, about a pint of blood in the vessel.

Examination showed patient with good color, pulse 85, with mild uterine pains, and blood flowing in alarming quantity from the vagina; cervix uteri long, external os large and open, internal os well marked and firm, and neck thick. Sweeping the finger around inside the uterus as high up as could be reached revealed nothing unusual. A diagnosis of accidental detachment of a normally implanted placenta was made. ʒj of Squibb's fl. ext. ergot was administered, and medical aid summoned. By the time assistance arrived the hemorrhage had ceased, uterus was firm and membranes tense.

It was decided to continue the ergot and wait developments. Uterine contractions increased, and the first stage of labor was completed, without anything unusual occurring, at 2 P. M., on the 11th, making fourteen and one-half hours from the time she was awakened; the duration of the second stage was fifteen minutes, and the third stage about three minutes. Presentation vertex, position L. O. I. A.

Placenta appeared at the vulva immediately after the birth of the child; it was expelled without the use of any traction. Large, black and firm clots followed the placenta, some as large as a tea-cup. A large clot was attached to the placenta at one edge, and dipped down to the bottom of sulci, between the cotyledons, and could not be detached without force. At the bottom of the sulci, the placenta was somewhat torn.

Dr. Streett, continuing, said he could not determine whether this tearing of the placental tissue was ante-partum or whether it was post-partum. and due, probably to compression of placenta during expulsion.

A point of interest is the source of hemorrhage. Some of these cases are due to nephritis—the soft placental tissue having vessels where the walls are evidently degenerated and rupture during the course of the nephritis, much the same as those of other parts of the body. There was in this case a history of the patient (on June 9) feeling somewhat strained on boarding a street car. Could it be that at this time the placental vessels were ruptured, and clots formed, and that the subsequent hemorrhage was due to muscular action, the blood then finding its way externally? He was much impressed with the gravity of these cases. In the last twelve or thirteen years he had seen six cases of this kind. One died within fifteen minutes after his arrival, and before she could be delivered. His confrère, in this case, introduced his hand and found detachment of the placenta. He had found ʒj doses of fl. ext. of ergot to be of service in these cases.

DR. WM. H. NORRIS said Dr. Streett does not tell us whether or not any efforts at abortion had been made in these cases. He had a case similar to these some time ago, from injury, and there was a clear case of trauma. These are points of interest, and it is to be regretted that Dr. Streett did not enter more fully into the etiology. He was fully in accord with the treatment used, and has found, in a practice of over thirty-five years, that ergot used judiciously in such cases acted well and promptly, notwithstanding

[1] See page 356.

the fact that most obstetricians to-day teach that ergot should not be used until the uterus is empty.

DR. E. M. REID said in using ergot in these cases, at term, where the os is not fully dilated, he thought small doses of 10 or 15 minims would suffice to lessen the interval between the pains and to keep up general contractions, and that the large doses should be reserved until after the delivery of the child. In one case of ante-partum hemorrhage at six months he tamponed the vagina, and removed the packing in twenty-four hours; the case went on to full term. This shows that packing the vagina is not *always* dangerous. The simple question is that you are to exercise judgment, and treat each case on its own merits; you cannot lay down any infallible rules to govern all these cases alike. If you watch them and are attentive, you can tide them over. When a woman has lost a large amount of blood, she is not in condition to be subjected to any heroic treatment; he has seen cases, where to have proceeded at once to induce labor, would have been fatal. If you can tide over your case until your patient can make up for this loss of blood, she will then be in better condition to be subjected to induced labor.

DR. J. W. CHAMBERS said he thought in a case where a woman was bleeding alarmingly, the only safe plan to pursue was to empty the uterus immediately. He did not think that ergot does good except to close the vessels. As to packing the vagina, he though the day of the tampon was over; it hides the hemorrhage, and has a moral effect on the patient, but the hemorrhage is going on all the same.

DR. DAVID STREETT said as to attempts to do abortion, these cases were in ladies of family, and were all near term, so that abortion was not to be thought of, as there was no possible motive for it. An interesting point in these cases is after giving ergot. When should the membranes be ruptured? In two of these cases the membranes were ruptured, in three the membranes were not ruptured until the os was well dilated. In all five the labor proceeded normally after the hemorrhage was controlled. He thought that if the integrity of the membranes could be maintained, we have a better chance of controlling the hemorrhage.

DR. A. V. GOSWEILER read a paper entitled

INFANTILE PARALYSIS.

DR. WM. H. NORRIS said Dr. Gosweiler has given us an exhaustive paper on this interesting subject. The differential diagnosis between infantile paralysis and other forms of paralysis is important. When called to a case we must diagnose between it and multiple neuritis. The latter is more frequent in the adult, while infantile paralysis or polio-myelitis is more frequent in children. Another point to bear in mind is that multiple neuritis attacks the upper extremities more frequently, while polio myelitis most often attacks the lower extremities.

DR. F. C. BRESSLER said Dr. Gosweiler's paper is so exhaustive that there is little to say. The name infantile paralysis is an unfortunate one, as it is meaningless and does not convey anything to the mind. Polio-myelitis, on the other hand, conveys to the mind a definite idea as to the lesion, and is to be preferred on that account. There must be some reason why this disease occurs more frequently in children than in adults. An explanation may be found in the rapid development of the spinal cord, in proportion to the other parts of the body in childhood. Trauma is seldom a cause. He thought it probable that it was an infectious disease. The characteristic feature of the disease is the immediate paralysis, its subsequent developments being improvement. He doubted if any cases get entirely well. If we have a destruction of a nerve cell, he could not see how it could be replaced or renewed.

DR. E. M. REID reported a case of Convulsions in a Pregnant Woman. He said he wished to present his case because of its medico-legal aspect. On the 24th of May, was called to see a lady with convulsions, who was six months pregnant. She had had two convulsions, was having one at the time of first visit, and had one afterwards. Her face was swollen and œdematous; in fact, the whole body was anasarcous. A small quantity of ether was used to control the convulsions, and as soon as she could swallow she was placed on fl. ext. jaborandi ʒss every four hours, also ʒss doses of cream tartar every six hours. The jaborandi was followed by profuse sweating, and the cream of tartar produced copious stools. A test of the urine showed it to be almost solid albumen. She is now taking inf. digitalis ʒss every four hours. The swelling has disappeared now, and it can be scarcely recognized, even about the ankles. There is a disappearance of the albumen also.

The consensus of opinion seems to be that the os should have been dilated, and she should have been delivered as soon as the convulsions came on. But the question arises, Should you induce premature labor when you find solid albumen? What is the proper mode of procedure in cases of this kind? At first she passed about two ounces of urine in twenty-four hours, now she passes from one to two pints daily. In the event of a patient's doing apparently well under these circumstances, should we proceed to carry out the rule and produce premature labor?

DR. F. C. BRESSLER said when Dr. Reid gets home to-night, if he should learn that his patient had died, what effect would the law have? If she passed two pints of urine yesterday and one pint to-day, he had better induce labor, and put her out of jeopardy. It is true that in most of these cases of nephritis in pregnant women, they are due to previous attacks, but if it were his case he would empty the uterus.

DR. J. W. CHAMBERS said the question for Dr. Reid to determine is this: If the condition of the kidneys is due to the pregnancy, then the uterus should be emptied. If it is an acute nephritis, independent of the pregnancy, then the proper treatment is to do just what he is doing. The solid albumen was shown *after* the convulsions. Now it becomes a question whether the albumen was not the result of the convulsions, rather than the cause of them. He thought if he should be called to see a woman with convulsions in the sixth month of pregnancy, he would induce labor and empty the uterus.

DR. REID said by what means can you determine what is "reasonable care and skill?" It would be well to have the opinion of those who are experts in this branch of obstetrics. When the science of medicine reaches such a stage where we can lay down absolute rules, then we may proceed to carry them out in any given case. Under similar circumstances, a gentleman induced labor on the grounds that it were best to empty the uterus; he lost both the child and the mother. Was this "reasonable care and skill?" Yet he was carrying out the rule. So far this case is improving, and it seems to be a case of acute Bright's disease, coincidental with pregnancy. It is now pushing on to the seventh month, and you know that a six months' child rarely survives after an induced labor. Her condition, to-night, is the same as the

vast majority of cases of pregnancy are in; there is a small amount of albumen and no œdema.

J. Wm. Funck, M.D., *Secretary*.

1710 W. Fayette Street.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

THE following are some of the many interesting papers read at the St. Louis meeting October 14, 15 and 16, 1891:

TEMPERATURE NO GUIDE IN PERITONITIS,

Was the subject of a paper by Dr. H. C. Dalton, Superintendent of the St. Louis City Hospital. The doctor has become so skeptical on the subject of fever in peritonitis that he is no longer guided by the thermometer in considering the advisability of an operation in abdominal cases. He takes the temperature in all cases and weighs it for all it is worth, but does not let the lack of fever deter him from operating when other symptoms, on which he has learned to place far more reliance, would move him in the opposite direction. A number of cases were reported going to prove the presence of peritonitis in the absence of fever. He concludes that when fever is present in belly cases it is well to remember that it indicates peritonitis, its absence, however, does not warrant us in saying that peritonitis is not present, and should not blind us to the actual condition.

An interesting case of

PACHYMENINGITIS INTERNA,

With report and presentation of specimen, was the subject of a paper by Dr. F. C. Hoyt, of St. Joseph, Mo.

GASTROSTOMY FOR IMPERMEABLE STRICTURE OF THE CARDIAC END OF ŒSOPHAGUS,

Was the subject of a paper by Dr. Arch Dixon, of Henderson, Ky. The patient, who recovered, was presented to the Association. Subsequent dilation of the stricture was accomplished.

The Lights and Shadows of a Doctor's Life, was the subject of an address by Dr. Joseph Mathews, of Louisville, Ky. The doctor's remarks were from the ludicrous to the grave, and at times brought tears, and at times shouts of laughter.

THE SEWERAGE SYSTEM OF CHICAGO,

Was the subject of a paper by Dr. John B. Hamilton, of Chicago, which was listened to with much interest, in spite of the depth of the subject.

The President's Address was delivered by that official, Dr. C. H. Hughes, of St. Louis. After discussing and recounting the wonderful progress of medicine in recent years, the doctor then took up specialists and specialism. The true specialist should be largely a consultant to the general profession and mainly indebted to it for his practice. In discussing moral and social relations, he said that physicians are, as a class, honest men. We are often charged with incompetency but seldom with dishonesty—never justly the latter—for medicine, whatever her faults of head has none of heart toward mankind. She is the peer of all professions.

How Medicine has Helped Mankind was next discussed, and the ways found to be quite numerous.

Non-political Interference with Public Medical Charities, was considered. Where the spoils of political conflict were human victims, minds dethroned and sacrificed to medical incompetency and party policy, we should secure for them the proper medical as well as custodial care. We should endeavor to so influence public opinion and to so use our ballots, that parties and politicians so politic and inhuman as to sacrifice the mental and physical maimed or ill in public hospitals and others of our eleemosynary institutions, whom it is our special duty, under Providence, to guard, shall know the profession's indignation and feel its power.

The doctor, in politics, has too long held aloof from the affairs of state, and as a consequence the great names of our medical history have no monuments to perpetuate their fame. Had we but looked well to our interests the President's Cabinet would long since have been represented by one member of the profession, as law, agriculture, finance, etc., we should have the Medical Minister of Public Health, for which the American Medical Association is just now pleading.

PELVIC INFLAMMATION IN WOMEN—A PATHOLOGICAL STUDY.

Paper read by Dr. W. W. Potter, of Buffalo.

The author affirmed that pelvic inflammations and their residues constitute about one-third the diseases the gynecologist treats, hence the importance of frequent discussions of all moot questions relating to the subject. He briefly reviewed the anatomical relations of the pelvic organs, calling attention to their enormous blood and nerve supply, which became both their weakness and their strength. He contrasted the pathology of Bennett, 1843, with that of Emmett, 1873, and the latter with the teachings of Tait, Price, Hegar and McMurtry of the present age. He referred to the pathological studies of Bernutz and Goupil of thirty years ago, and affirmed that the observations of the present had served to confirm the correctness of these pioneers.

He next asserted that the pathology of to-day had been established by operative surgery, which had shown that pelvic inflammation begins in the tubes or ovaries, and extends to adjacent structures through absorption or by contiguity; that it almost never begins in the cellular tissue, but may be carried there through the tubes and ovaries by infections, either specific, puerperal or traumatic. He affirmed that the inflammation was in most cases a peritonitis, intra-pelvic or local in character, and not a cellulitis; that para and perimetritis were misleading and confusing terms, hence should be dropped, and that the so-called pelvic abscess was a sequence of salpingitis, ovaritis or peritonitis, not a primative accumulation in the areolar tissue itself.

The tentative management in these cases, rest, counter-irritation, hot sitz baths, vaginal douches, and attention to the digestive organs and general health, resulted in only temporary improvement, or in cure in a very small percentage. Those reported cured were generally, if the history could be known, subject to repeated relapses, and a frequent recurring pelvic peritonitis usually indicated leaky tubes. Electricity, too, had disappointed its most sanguine advocates and need not be considered.

In conclusion, he asserted that if these views be accepted, the logical deduction was to watch the early manifestations of the disease carefully, that competent surgical skill be invoked before the damage to important structures became too great to justify the expectation of successful operation.

OBSERVATIONS ON SURGICAL TREATMENT OF UTERINE TUMORS,

Was the subject of a paper by CHARLES A. L. REED, M. D., of Cincinnati.

He said there are certain solid tumors of the uterus that require no operation, but there are others which are uniformly recognized as demanding operation. They are for the most part rapidly growing tumors in young subjects; removable fibro-cystic tumors; soft œdematous tumors; large bleeding fibroids and those growths which give rise to ascitic accumulations. Attention is called to certain other classes of tumors in which operation was not usually advised, but the demonstrated dangers of the growths rendered surgical interference important if not imperative. These cases are small tumors of sub-mucous polypoid development in which there is a sero-sanguinous discharge, but in which a slight menorrhagia, but no further hemorrhage, leads to no apprehension of danger. Another class of smaller sub-mucous growths are generally pronounced bleeders, but the absence of gross enlargement of the uterus disarms apprehension on the part of the attendant. After citing at length a number of cases operated upon for these tumors, the author drew the following conclusions:

1. All persistently hemorrhagic uterine myomata of whatever variety should be advised early operation.

2. In young subjects with multinodular tumors, giving rise to alarming hemorrhage, the appendages should be removed when practicable as an alternative for total extirpation. But the latter operation should be done whenever the character of the growth will permit of its removal by dangers less than those which would be involved by its continued existence.

3. To these tumors already recognized as demanding operation, should be added those of uterine development which are liable to dangerous constriction by the uterine walls, and in which their destruction by this means might induce sepsis.

4. All cases of sub-serous growth, indolent, yet progressive in character, in which the tumor has become a menace to neighboring organs, whether hemorrhagic or not, should have exploratory incision with reference, first, to removal of the appendages, or second, of the neoplastic organ.

5. All growing tumors in women occurring beyond the menopause should be removed, if possible, by vaginal total extirpation, or by abdominal section.

6. All distinctly operable cases demanding interference should be advised operation at the earliest practicable moment.

The Polyclinic.

JEFFERSON HOSPITAL.

A VERY important thing in cerebral surgery is, always to have ready hot solutions, as the patients often show signs of collapse, in which event a douche of hot water, or bichloride or carbolic acid solution, or any hot antiseptic or aseptic solution applied constantly to the head, is the best means for restoration.

I have here a bottle of—we will call it—salve, consisting of wax, carbolic acid, and other ingredients, for the purpose of puttying up the bones of the skull, in cases of serious hemorrhages which may occur in cerebral operations from the vessels between the tables of the skull. I use it for hemorrhage from a small vessel; if large, I would not hesitate to drive in a bit of antiseptic match-stick, or catgut, or, better still, to crush the bone.

Whenever you open the skull, always open the dura mater. This is not a rule without exceptions, but almost so. When you have gone so far as to cut down to the dura, open it and look at the brain, as you may learn that which will require you to go on. You may learn that, which if you miss, you miss the whole pith of the operation. If I find nothing, I sew up the dura again.—*Keen.*

Why does amputation through the knee give the patient a better chance than above? If you amputate through the femur, you open the medullary cavity and have danger of osteo-myelitis, which was one of the most terrific causes of death during the civil war. Therefore, I did this amputation at the joint, because I wished to spare the medullary cavity, for when you open that canal, you are apt to have large sequestra and constitutional disturbance.—*Brinton.*

Prof. Brinton gave the following prescription to be used by injection into the bladder for its calmative effect, in irritated conditions of that organ:

℞.—Uva ursi	℥j
Lupulin	ʒss
Boiling water	Oj
M. et add.	
Bicarbonate of potassium	ʒij
Paregoric	ʒj

PENNSYLVANIA HOSPITAL.

THE characteristic stool of typhoid fever, as you probably have heard, is a stool of the consistence of pea soup; a thin yellowish stool, with small lumps suspended in it, of a very offensive odor. Often, however, you do not have the characteristic passages.—*Fisher.*

If a patient comes to you with a slow pulse, 80 to 90, and a temperature of 103° to 104°, there is probably very great reason to suspect the beginning of typhoid fever, particularly if he has complained for some days before, of violent headache, feeling as if there was an immense weight on the top of his head. That pulse-temperature ratio is hardly seen in any of the other acute exanthemata.

You know that the diagnosis at first may be difficult between typhoid fever and pneumonia. I have often seen such a mistake made in a patient suffering from pneumonia, particularly in the stage of congestion. There may be only a few rales, and the patient may be in a state of mental hebetude or dullness, yet, if you will examine, you will notice that the pulse is rapid in pneumonia, at least, more rapid than that of typhoid fever. So it is that the diagnosis may be difficult at first between typhoid fever and meningitis. You know that often typhoid fever is complicated by meningitis, but, as a rule, if the disease is meningeal from the start, the pulse is a rapid pulse, and that is an important distinction.—*Fisher.*

As a rule, I think physicians are getting to trust less and less to internal medication in typhoid fever; but where the tongue is heavily coated, and there is very severe headache and a good deal of abdominal pain, then, in the early days, say the first or beginning of the second week, it has been my custom to order a few small doses of calomel until the bowels are freely moved, that is, unless free diarrhœa has occurred before. I generally order gr. iij of calomel, divided into twelve powders, one powder every three

hours until the bowels are moved. Of course, if any diarrhœa occurs, the powders are at once stopped. Generally speaking, the bowels are easily moved in the early stages, and we must avoid any purgatives that will increase the irritation already existing. I think calomel, in divided doses, can be given without fear, particularly in the early stages of the disease.
—*Fisher.*

The cold bath (a portable bath-tub at the bedside) has been used in the women's ward of the Pennsylvania Hospital in treatment of typhoid fever, and out of 20 cases under treatment, there has been no deaths.
—*Fisher.*

Dr. Meigs presented a case of exophthalmic goitre. In regard to treatment he said: There is a great deal of difference in opinion as to what should be done. I saw, in "Fagge's Practice of Medicine," somewhat to my surprise, that the tincture of iron, as a general thing, is not only useless, but injurious. That is quite contrary to what I have found and to what we follow. It has been my custom to give Basham's mixture, and it seems to me to have a beneficial effect. In the hospital we usually treat the patients with iron, to a greater or less extent, and digitalis in such amount as to steady the heart's action and increase its force. My own belief is that you may give gtt. x tr. of digitalis, and continue it indefinitely without danger of its cumulative action if you do not go beyond that quantity. If larger doses are given, you should keep your patient under observation. My custom has been to give the above dose, sometimes increasing the amount, and I have found, in these heart conditions, particularly where there is a large nervous element in the disease, that an additional dose of digitalis at night before going to bed, steadies the heart's action and induces sleep. So, my treatment would be, gtt. x tr. of digitalis, in water three times a day, and a fourth dose before going to bed if the patient cannot sleep. So also, when you have a heart trouble that is curable, I think you will find that a small or moderate dose of digitalis, on going to bed, will favorably effect the heart's action and induce sleep.

In these inflammations (gonorrhœal rheumatism) it would seem to me that the inflammation is of the joint surface itself, more than of the tissues around the joint, and that is why we have such intense pain. The prognosis is generally good, except for the danger of some permanent injury to the joints.

Treatment.—Although for my own part, I do not see that salicylic acid or its derivatives are of much value in these cases, yet I almost always try them, and do not feel that I have done my best for a severe case until I have given pure salicylic acid. I have seen cases where ʒj doses of salicylate of soda had no effect, and on substituting ʒj doses of salicylic acid, have entirely relieved the pain. You should begin with the salicylates, and then give salicylic acid, and if, after three or four days, you get no result, use iodide of potash gr. v-x three times a day, and other remedies as they are indicated.—*Meigs.*

PHILADELPHIA HOSPITAL.

TREATMENT OF SYPHILIS.

WHERE the patient is in good, strong, healthy condition, I give him protiodide, because it has not a cumulative action. It does not remain in the system and suddenly give rise to ptyalism. Besides, it is more manageable, and you can more readily find out just how much the patient can take. I start with gr. ½ in pill form three times a day after meals. After three days, the patient takes two pills after dinner; after three days more, he takes two after supper; and three days after that is taking two pills after each meal. The dose should be increased in this way until there is some griping or diarrhœa, when the number of pills should be gradually decreased until the patient experiences no discomfort. In this way you can find out how much he can take. Then the weight of the patient should be taken every week. He should remain stationary, or gain in weight under proper antisyphilitic treatment, as he is taking the tonic dose, so that at the end of a couple of years he should be in better condition than ever.

The mercury should be continued for two months after all lesions have disappeared, and should then be discontinued for ten days. After this interval resume the mercury again, and at the end of two months reduce the dose one-fifth, keeping the patient on the reduced dose two months longer. Then stop the mercury entirely for one month, and so, intermitting, go on for two years, at the end of which time keep him under observation without treatment for one year, and if, during that year, the patient shows no sign of disease, you are safe in telling him he is cured, but if during that last year he should show further symptoms, you should continue treatment for eight months longer.

I am in the habit of giving with the mercury sulphate of morphine gr. $\frac{1}{24}$, which prevents griping; also tartar emetic, gr. $\frac{1}{24}$, which stimulates secretions and prevents accumulation of the mercury. At the end of six months I drop all except the mercury. In ninety-nine cases out of one hundred iodide of potash is not necessary. In those cases where you have the early appearance of the late secondary symptoms, it is beneficial in gr. x doses.

There are some cases in which you cannot make use of the protiodide alone. When the man is debilitated and broken down, then you must combine tonic treatment; blue mass, with sulphate of iron, gr. j; quinine, gr. j; and powdered opium, gr. ½, three times daily. Corrosive sublimate, with tincture of the chloride of iron, may be given. I sometimes let the patient take protiodide before meals, and iron after meals.

Some cannot take mercury by the mouth, it giving rise to dyspepsia. In these cases corrosive sublimate may be given hypodermically, but this method causes a great deal of pain, and is likely to cause abscesses.

Inunctions of mercury are good, especially in young infants. Wash one foot, cover with blue ointment, and over it place a thick woolen stocking, which is kept on for twenty-four hours, after which the foot is washed, and the other foot treated in the same way. This is kept up for four days, and dropped for four days. In young infants you can apply the mercury under the binder.—*Horwitz.*

MEDICO-CHIRURGICAL HOSPITAL.

PROF. LAPLACE presented a case of fracture of the ascending portion of the lower jaw, complicated by the broken ends having caused a lacerated contused wound of the cheek. The jaw was rendered immobile by a pasteboard splint passing in front of and under the chin, retained by the proper bandages. Commenting on the laceration, he said:

It is difficult to treat.

1. Because it is a contused wound.

2. Because it is made by the teeth, which are laden with germs, the human bite being just as dangerous as that of any other animal.

The third reason is that the wound being in the mouth, those germs which make an ordinary bite by human teeth so dangerous, are constantly in contact with the wound. Hence these wounds are foul, have a bad smell, and the antiseptic principles cannot be applied. On the outside of the cheek the result of our treatment has been good, and we will remove the stitches. The wound inside the mouth must remain infected. There is no culture medium better fitted than the mouth to develop all the germs that can be developed.

In typhoid fever, during the stage of decline of fever, you do not generally have any dangerous complications arising.

You should give calomel, if at all, only in the beginning of the disease, when the strength of the patient is good, and the bowels are not as yet so loose. It is a good plan, perhaps, where there is a fair degree of strength, especially if there be constipation, every other day to give gr. v–x of calomel in addition to the antipyretic treatment. It seems to be the experience of those who have used calomel most, that the fastigium does not rise so high as in those cases where it is not used.

Do not give calomel within four or five days of the fastigium, and withdraw all depressing antipyretics you may have been using in the earlier stages of the disease, such as acetanilide, and give quinine gr. x night and morning.

There is no necessity, as a rule, for giving more than gr. v of acetanilide. I have found that gr. ij at night will reduce temperature to the same extent as five, or even ten grains.—*Anders.*

As to the treatment of typhoid fever, when the disease is passing off, and temperature has reached the normal point, we do not need longer to give antipyretics for their antipyretic effect. If we assist the healing of the ulcers, the fever will take care of itself. We are giving quinine in gr. ij doses, four times in twenty-four hours, for its tonic effects; also salol for its antiseptic action. Bear in mind that as soon as the temperature is normal, free stimulation is not only useless, but absolutely injurious; milk punch is given two or three times daily. We are also giving tr. cinchona ʒj every two hours. German authorities tell us that seven to ten days should elapse, from the time the temperature has become normal until the patient gets out of bed, which, I think, is correct. Some advise getting up earlier, but if getting up too early does not produce a relapse the patient is more apt to commit some error as to diet and cause a recrudescence of fever which may last seven to ten days longer. Insist on keeping the patient in bed, at least a week from the first normal morning turning temperature, and prohibit all solid food during that time. While errors of diet may not have the power, *per se*, of producing a relapse, yet they seem to have the power where some virus remains latent in the system of arousing it to activity. It may be that the virus would have produced a relapse later on, anyhow, but I have seen relapses follow errors of diet. However, when all the virus is out of the system, errors of diet could not produce a relapse.—*Anders.*

THE regular quarterly business meeting and collation of the Medico-Legal Society of Philadelphia, was held at Horace B. Wimley's, 1604 North Broad street, on Tuesday evening, 27th inst., at 8 o'clock.

ACUTE YELLOW ATROPHY OF THE LIVER.—The patient was a married woman, twenty-six years of age, of good development and previous health. Her family history was negative, with the exception that her mother had died of phthisis. About January 7, of this year, she came to my office to see me with reference to a marked jaundice which she had. A week previously she had suddenly been seized with very violent, agonizing pain in the right hypogastrium, which was attended with vomiting, and followed in three days by rapidly-developed jaundice. The pain diminished as the latter condition increased.

I did not see her again for two weeks; during this interval she had more or less pain about the liver, occasional vomiting, fever at times, with now and then a rigor and heavy sweat. When I saw her she had a temperature of 105° F. She was exquisitely sensitive to pressure over the right hypochondrium and the epigastrium. There was considerable tympanites, so that it was impossible, then or later on, to determine the outlines of the liver. She was still intensely jaundiced. The stools were free and clay-colored. The temperature from this time (twenty-first day) on underwent most marked and irregular variations (from 99° F. to 105° F.), as did the pulse. Occasionally, during the fourth week, there was severe epistaxis and moderate hematemesis. The urine at no time showed any albumen. About the twenty-seventh day there was evidence of fluid in the peritoneal cavity. At this time a peculiar coma-vigil gradually developed, increased to absolute coma, and led to a fatal termination on the thirtieth day. A few hours before death a few petechiæ appeared on one leg.

The post-mortem revealed the following condition: The first cut through the abdominal muscles revealed semi-fluid extravasations of blood in their substance. About a quart and a half of bloody serum was found in the abdominal cavity. All the organs were intensely jaundiced, and under the peritoneum everywhere, in the bladder and kidneys, were found extravasations of blood. The liver was fastened by recent adhesions, over a space about as large as one's hand, to the diaphragm. The liver itself was very much reduced in size; weighed but thirty ounces; had a smooth, non-adherent capsule; was intensely yellow on section, and very soft, almost diffluent, in consistence. The whole surface was free of lobular markings. All the other abdominal organs were normal.

Dr. Holt made sections, and found the typical microscopic appearances of that rare disease, *acute yellow atrophy.*

In conclusion, I would refer briefly to the points of agreement and disagreement between this case and the classical type. It differed in the very sudden and painful onset; in the absence of albumen during its whole course; in the presence of ascites, and, above all, in the long duration of the case, about thirty days. Thierfelter, in a list of 118 cases of this disease, found 114 to end fatally before the seventh day, and but one to reach the fourteenth. These, then, were the distracting features of the case. It agreed with the type in occurring in a female (this generally being true); in occurring in middle life; in the marked fluctuations of temperature and pulse; in the hemorrhagic symptoms, epistaxis, hematemesis and petechiæ; in the hematoxic symptoms, delirium, coma, etc., and last, but not the least conclusive symptom as to the nature of the case, in the fatal termination.—Van Zandt, *Lancet-Clinic.*

The Times and Register

A Weekly Journal of Medicine and Surgery.

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THE TIMES AND REGISTER,
FORMED BY UNITING THE
PHILADELPHIA MEDICAL TIMES,
THE MEDICAL REGISTER,
THE POLYCLINIC,
THE AMERICAN MEDICAL DIGEST,
PUBLISHED UNDER THE AUSPICES OF THE
AMERICAN MEDICAL PRESS ASSOCIATION.

Published by the MEDICAL PRESS Co., Limited.

Address all communications in regard to Editorial and Subscription Business, to 1725 Arch Street, Philadelphia.

Address all communications in regard to Advertising, to 218 E. 34th Street, New York.

New York and Philadelphia, October 31, 1891.

A LITTLE KNOWLEDGE BETTER THAN NONE.

PROGRESS in medical matters, as in everything else, is in waves. Our forefathers were bled and purged, puked and salivated to death's door and beyond for trivial ailments, until homœopathy proved that people got well without any treatment, unless we consider the mental bamboozle of sugar pills a treatment.

With some modifications, the modern patient still oscillates between the extremes of having too much or too little done for him. Surgeons are trephining when there are no localized symptoms to justify it, and in certain cases of Jacksonian epilepsy, opportunity of an almost certainty of curing the patient by this means is neglected. To particularize, a lady aged thirty, with strumous adenitis had her breasts amputated for alleged scirrhus, and was induced to remain for years in an alleged hospital, resigned to the belief that there was no hope. She had been robbed of her time and money, and her enjoyment of life by ignorant frauds who had her in charge, and as might be expected, the physician who advised her of the true state of affairs and restored her to her family and usefulness received nothing for his services.

A pretty little married lady of twenty-five, was silently grieving over a diagnosis of cancer of the breast and the contemplated operation, when her sister's physician was accidentally consulted and pronounced the case to be one of simple mastitis, which yielded promptly and completely to judicious bandaging. Is it any wonder that the cancer quacks coin money out of the credulity of the public? On a par with this is the frightful abuse of bromides and morphine. Senile patients will be drenched with these to the verge of death, and rapid recovery will follow upon their withdrawal.

When people advance in intelligence enough to learn the true inwardness of why they often get well under faith cure, Christian Science, or in spite of injudicious treatment, they are apt to run to the nihilistic extreme and decry all medication whatsoever.

Between the "laissez faire" cranks and the patent medicine gulpers, there are a few sensible people who have been educated into taking care of themselves by their family physician, and have acquired a respectable knowledge of what honest medication will do. There is an old saw to the effect that "a little knowledge is a dangerous thing," the truth of which Huxley denies, and claims, that had the little knowledge of the circulation now obtainable by any child in school, been known by Harvey in his day "he would have loomed upon the nineteenth century as an intellectual portent." So far from a little knowledge doing harm, particularly in medical matters, it would be well if the laity in general had the least modicum of it disseminated among them, in self-protection against the practitioners who know as little as they do. But it seems as though a general diffusion of this little knowledge were about to take place when everybody and his wife nowadays matriculates at some "medical school," and as only a small percentage "graduate," the majority become all the better patients for having learned what they did.

In the millenium every one will know enough of medical matters to enable the starvation of the legions of poor creatures who nowadays "practise medicine."

S. V. CLEVENGER.

THEY HAVE EYES, BUT SEE NOT.

It has always been a problem in therapeutics how best to introduce iodine within the system. The iodides of potash, soda, ammonium, have been regarded as the most feasible, and have proved fairly satisfactory. Nevertheless, there has been a lurking feeling that there must surely be something better, evidenced by the fact that all the antiseptics of iodine origin have been administered internally—with but small success, however.—*Canada Practitioner.*

SUCH items as the above are a never-ceasing source of wonder to us. Where are people's eyes? And ears? Things are advertised week by week that are of a value beyond all estimation to the doctor, and yet he never seems to know of them. One man once bewailed the absence of an efficient remedy for diphtheria. We asked him if he had used peroxide of hydrogen. No, he hadn't heard of it. We looked at him sadly, and informed him that Mr. Marchand had been telling him of the virtues of that wonderful remedy every week for over a year. But he "hadn't read the advertisements." A few weeks later he was simply wild about peroxide.

Such men are hopeless. They show enough animation in complaining of the inroads of specialists, quacks, and advertising druggists; but it never occurs to them that if they took some pains to inform themselves of the improvements in therapeutics there would be no field for quacks.

If the treatment of alcoholism had received the attention it deserved, there would have been no Keeley.

Mr. Carnrick finds the greatest difficulty in the way of his food lies in the ignorance of the practitioner concerning the physiology of digestion.

Mr. Gardner has gone to great expense in calling the attention of physicians to the value of hydriodic acid, as a means of overcoming the difficulty alluded to by our Canadian contemporary. And so with many other articles, that we might mention; whose neglect by the profession is simply incomprehensible.

Years ago we made it a rule to give a trial to every new thing that seemed to warrant it. The result has been so satisfactory that we turn eagerly to the advertising pages of our journals to see what new prizes are offered. Of course, some prove to be failures, and may even carry their failure on their face. For instance: An agent of the irrepressible type, one of those the profundity of whose ignorance is only equalled by the amount of his gall, spent some of our time in endeavoring to convince us that the only possible way we could get iron into our patients' blood was by the use of some German mess he advocated. His argument was, that as the use of iron blackened the stools, none of it was absorbed. We mildly insinuated that we *had* succeeded in giving iron, as shown by actual tests, with the hemacytometer; but this argument he treated with the contempt it deserved.

His preparation proved to be a very mild chalybeate, not any better in any way than a number of the ordinary ferruginous preparations.

These remarks apply to all classes of the profession. Frequently, in consultation with men of acknowledged standing, whose names are known far beyond the limits of the community in which they reside, we have been struck with their ignorance of the newest materia medica. Professor Tom wanted to know why we suggested the normal liquid instead of the tincture, when his patient's heart needed exactly so much digitalis and no more. Surgeon Dick proposed calomel and jalap' when the flatulent dyspepsia with chronic constipation called for maltine with cascara; and great gynecologist Harry, who has reluctantly agreed to spare the ovaries while we cure the dysmenorrhœa and headache with antikamnia, thinks that if hypodermics of morphine and atropine fail to cure, it's hardly worth while to try these new-fangled things. But—we started in to refresh ourselves with a good growl, and the result looks very much like an advertisement!

Annotations.

A CASE of incoördination with numbness of the feet and legs extending upward to the middle of the shins, and from the tips of the fingers to the centers of the palms, was caused by cocaine and morphine addiction, coupled with other debilitating dissipations, such as sexual excess, in a patient of thirty, who sought my advice in his rounds among the physicians.

One "professor" of neurology diagnosed his case as Landry's ascending paralysis, which usually terminates fatally in two weeks, and in which there are no sensory symptoms. After four months I received a letter from him in which he claimed to be recovering. The "professor's" students are doubtless diligently drilled in a varied and extensive assortment of misinformation.

S. V. CLEVENGER.

FEW men really grudge payment for satisfactory work. When a patient comes to the office for the first time, give him an hour and charge him well for it; instead of a routine five-minute interview and a routine fee. If his case demands steady treatment for an extended period, charge him a lump sum and let him see that he gets the worth of his money by coming regularly. If the case is a chronic incurable one, make a fixed charge per quarter. By such means you will keep your patient from running off to other practitioners, and will do him very much more good, than by simply giving detached prescriptions when he happens in.

IN the "Medical News and Miscellany" of this number will be found a digest of the rules and conditions under which patients are admitted to the hospitals of Philadelphia. This has been prepared by Dr. S. Traner Buck, the materials being obtained, by correspondence and visits, from the hospital authorities, with much labor. It was intended to publish this data in tabular form; but our pages proved to be too small for such extensive tables, and we were compelled to put the matter into the present form. The same data in regard to all the other charitable institutions of Philadelphia has been prepared, and will be published in the ensuing numbers of THE TIMES AND REGISTER. The object is that our readers may have in their hands all the necessary information in regard to the city hospitals and other institutions that they may need in directing patients where to go, what cases to send to each, who will treat them there, the cost, accommodations, etc.

A SANITARY GUIDE TO THE WEST INDIES.

OUR New England editor, Dr. Hutchinson, of Providence, has completed his last work and sent it to press. "Under the Southern Cross" is its title, and it contains the best part of the series of articles published in THE TIMES AND REGISTER during the past year, together with much new matter collected by the doctor while South last winter. As it stands, it is the only book extant which is authority upon the different sanitariums of the West Indies and Spanish Main, besides being a charming book of travel, full of story, adventure and brilliant description.

By its aid, American medical men will be enabled to choose the proper place for patients whom they desire to send South for climate treatment, and avoid mistakes that may prove serious, while pleasure tourist will find in its pages all that they will care or need to learn of those attractive regions.

The book will be beautifully illustrated from the author's sketches and photographs.

As the edition will be limited, orders should be sent in at once, and may be directed to this office, or to Dr. Hutchinson, Providence, R. I.

Letters to the Editor.

EXHAUSTED VITALITY.

THE editorial on "Exhausted Vitality," in THE TIMES AND REGISTER of September 26, 1891, covers in all respects a case I am prescribing for. I am giving a general tonic treatment, with rest, etc. Can you suggest anything better? If you can, please do me the favor to do so, giving all particulars such cases require.

D. B. H.

[The first duty is to convince the man that he is ill; so dangerously ill that everything else must be sacrificed to the duty of restoring him to health. He must break off vicious associations and habits, leave his business, his cares, and his worries. The three great remedies are *rest*, *exercise*, and *nourishment*. *Rest* from mental work and care; often even the newspaper must be forbidden; the brain must lie fallow. Travel may be necessary; banishment from home is imperative. Exercise, graduated to his strength; of an agreeable sort. Hunting and fishing suit some; cultivating fruit or flowers, or regular farming suit others; herding sheep or cattle still others. The tastes and the means must regulate this largely. Nutrition is most important. Many cases need building up; the digestion must be regulated; cod liver oil, the phosphates, iron and quinine are often requisite. Whenever the patient's means will allow, he should be accompanied by his physician and live under his direction. It is in general necessary that the full period of one year be allowed for the recuperative processes to complete their work; and the return to the patient's previous avocation should only be allowed after careful consideration. In many cases the new life will prove so agreeable that the patient will adopt it permanently. W. F. W.]

CURABILITY OF LOCOMOTOR ATAXIA.

WILL you kindly inform me, throught he columns of your valuable paper, about what percentage of "Locomotor Ataxia" in your opinion are carable. Has me lical science made much advance ment in the last twenty years in the cure of this malady? W. M. DAVIDSON.

390 NORTH STATE STREET, CHICAGO, ILL.

[We are justified in classing locomotor ataxy amongst the incurable diseases. Some cases may recover in the early stages, but this is at a time when doubt may always attach to the diagnosis. Arrest and improvement can, however, be attained in probably the great majority of cases, and the intelligent application of means to this, and if it marks no "advancement in the cure," is positive progress in the treatment of the malady. There are few diseases in which the lesion, the course and the manifestations are more clearly established than in this, and hence few which can be more intelligently approached.

SAMUEL WOLFE, M.D.,

Prof. of Physiology and Diseases of the Nervous System in Medico-Chirurgical College, Philadelphia.]

[Nevertheless, there are cases in which the diagnosis has been made by skilful diagnosticians, in which an arrest of the disease, or even an apparent cure, has persisted for a number of years. It is begging the question to attribute these cases to "mistaken identity." If, as is claimed in France, ataxy is of syphilitic origin, there is no good reason why it should not be amenable to specific treatment. A case reported by the writer, in which he secured a cure, remains well after nearly eight years. W. F. W.]

Book Notices.

HIGHER EDUCATION IN INDIANA. By JAS. ALBERT WOODBURN, PH.D. Bureau of Education, Circular of Information, Nov. 1, 1891. Washington: Government Printing Office, 1891. Paper, 8vo; pp. 200.

THE PRACTICE OF HYPNOTIC SUGGESTION. Being an Elementary Hand-book for the Use of the Medical Profession. By GEORGE C. KINGSBURY, M.A., M.D., University of Dublin. Bristol, England: John Wright & Co.

This volume, the receipt of which we are glad to acknowledge, is intended "to acquaint its readers with the rudiments of practical therapeutic hypnotism," and to warn them of the obstacles in the way of its general adoption.

Among the many interesting facts in the book is the author's statement that "on a first trial, probably six out of ten average patients can be hypnotized, but that repeated trials will result generally in eight out of ten becoming hypnotized."

He finds that the prevalent idea that only persons of limited, or small mental or physical capacity, is a mistaken one, and that athletic persons and intellectual people with well-balanced minds, are often readily influenced.

In practice, he believes that it is clearly justifiable to use hypnotic suggestion in all cases where a distinctly nervous element can be detected, wherein it acts as a kind of mental or moral opiate, giving refreshing sleep and freedom from pain and anxiety.

Many cases are cited where patients have been cured of serious forms of disease by this suggestion, employed by the author, and he is completely convinced of its practical value. Even such deformity as traumatic contraction of fingers was treated in this way, a year after initial wound, and cured—to attest which photographs are printed.

Dr. Kingsbury's book is the first contribution to the therapeutics of hypnosis of any practical use that has come under our observation, and we are glad to recommend it to all who are investigating the subject.

W. F. H.

The Medical Digest.

A GENTLEMAN suffered with pain in the upper jaw, about where the root of the bicuspid had been. This resisted treatment, until the bone was opened, when a small piece of a tooth-root was found. This was removed, and the patient had no further difficulty.—*Western Dental Journal.*

IODOFORM INJECTIONS IN GOITRE.—Dr. Kapper, an Austrian military surgeon, has employed in fifteen cases, with invariable success, Mosetig's plan of injecting iodoform emulsion into soft thyroid tumors. In every instance there was a diminution in the circumference of the neck amounting to from 8 to 10 cm. Antiseptic precautions were employed, and in some cases where the tumor was of considerable dimensions several syringefuls were injected into different parts of the parenchyma. In order to ascertain whether the needle has entered the gland the patient is asked to swallow, when, if it has so entered, the downward movement of the syringe shows that the needle has been carried upward. In some cases the injections were repeated daily for several days, in others at intervals of a few days. In no cases were any untoward symptoms produced.—*Lancet.*

SMALL-POX AND VACCINATION IN CENTRAL AMERICA.—The *Gaceta Medica Quezalteca*, the first number of which has just reached us, states that in one of the recent epidemics of small-pox no less than 25,000 deaths occurred from the disease in the Republic of Guatemala; but that notwithstanding this terrible mortality, which is worse than that occasioned by war, the Government has taken no pains to introduce any scheme of vaccination, and the State is without any vaccination laws at all, being, indeed, as far as

sanitary organization is concerned, decidedly behind some other central American States, which, from its size and general importance, it ought at least to have equalled in scientific progress. A medical society has taken up the subject, but whether the Government can be induced to accede to its suggestions is very problematical.

THERAPEUTIC USE OF ORGANIC ANIMAL EXTRACTS.—At the recent meeting of the French Association for the Advancement of Science, Dr. Onimus, of Monaco, stated (*Sem. Méd.*) that he had used organic animal extracts of various kinds therapeutically with good results. Thus in a case of asystolism, he gave injections of cardiac muscle, which caused the disappearance of the suffocative attacks; the other symptoms, such as difficulty in walking, breathlessness, and general debility were improved by the injection of extracts obtained by macerating fragments of spinal marrow in glycerine. In a typical case of labio-glosso-laryngeal paralysis which had reached the last stage, the injection of extracts of nerve substance was followed by great improvement. In three cases of diseases of the cord—transverse myelitis, chronic meningitis, and incipient ataxia—definite amelioration ensued after similar treatment.

—*Brit. Med. Jour.*

ARTIFICIAL CORNEA.—The *Berlin Klin. Wochenschrift* publishes a seventh case of transplantation of cornea by Professor V. Hippel, of Königsberg. There was a dark-brown central decoloration of the cornea, three millimeters in diameter, and reaching down to the membrane of Descemet, which had been caused by the action of nitrate of silver. Cocaine having been applied, the non-transparent part of the cornea down to the membrane of Descemet was cut into by a little trephine, the crown of which was four millimeters in diameter, and carefully removed. The author then excised by the same means a similar piece from the whole thickness of the cornea in a young rabbit, and transplanted this to the eye of his patient. It filled the wound exactly, and was on a level with the rest of the cornea. Iodoform was applied, and both eyes were bandaged. Healing proceeded without any trouble, and in six weeks the patient was discharged with a completely transparent cornea.—*Lancet.*

EXCISION OF CHANCRE.—The bacteriological researches of Bouchard and Chauveau have demonstrated the fact that the intensity of an infection is (within limits) directly dependent on the number of pathogenic organisms. If, therefore, we remove the reservoir of infection by excising the chancre promptly, we are helping the organism in its struggle against the invader, and there is, at least, a theoretical possibility that the intensity of the infection will be mitigated. That this is actually the case, there is a considerable amount of evidence. At the Berlin Congress, Ehlers, of Copenhagen, reported thirty-seven excisions in which the patients had remained under observation for several years. In only 10 per cent. of these did severe forms of syphilis develop, whereas the proportion of cases of severe syphilis in general is about 35 per cent. Of 15 cases which Jullien operated upon, 3 showed absolutely no signs of syphilis later, and in a fourth the disease was so attenuated—if not wholly eradicated—that the patient acquired later a second syphilitic chancre. Leloir, in a recent paper, reports several cases in which absence of all symptoms followed after excision of the chancre.

We are warranted, from these and similar cases which might be multiplied, as well as from purely theoretical considerations, in the conclusion that there is some probability that a syphilis may be aborted by the early excision of its initial lesion, and a considerable probability that its course will be rendered more benign.

The question is certainly not *res adjudicata*. What is needed in its present stage is more evidence. Altogether, 400 or 500 cases of excision have been reported. I have no doubt that two or three times that number of operations have been made that were never published. Most of these probably were made at the time this method of treatment was first generally discussed, and in the six or eight years that have elapsed sufficient time has been afforded for a judgment of the effect of the operation in the individual cases. Physicians who have notes of such excisions and their results would do much to effect a final settlement of the value of the operation by publishing them.—Pollitzer, *Med. Record.*

THE YEAST TREATMENT OF TYPHOID FEVER.—In *The Lancet* of April 18, 1891, I mentioned that yeast was being held up as a specific for the cure of enteric fever, and that some of the physicians at the Alfred Hospital, Melbourne, were experimenting with it. The report recently issued deals with thirty-seven cases treated by Drs. Embling, Lemprière, and Barclay Thomson. Dr. Thomson writes: "In all, thirty-seven cases have been treated: Ten were severe, the temperature reaching or exceeding 104°; eight moderately severe, temperature reaching or exceeding 103°; eleven were mild, although the temperature reached 103°; eight were very mild, the temperature never being above 102°. In all, recovery took place without any relapse. When commencing the use of the yeast, it occurred to me that if the theory that relapses are due to reinfection from the intestine is correct, then there should be none under the use of the yeast, as all the bacilli would be destroyed in the intestinal tube. This is so far borne out, for there was not a relapse in the thirty-seven cases under yeast; while in the 107 cases otherwise treated in the hospital there were sixteen relapses. The average proportion of relapses is given by Fagge as 2 to 11 per cent."—*Lancet.*

LYDSTON ON PERITONITIS.—1. I do not believe in the existence of acute idiopathic primary peritonitis.

2. The majority of cases of so-called idiopathic peritonitis in children will be found, upon inquiry, to be traumatic.

3. Slight injuries of the abdominal contents are relatively more dangerous in children than in adults.

4. Acute peritonitis in children, while apparently idiopathic, is often secondary to perityphlitic inflammation, which runs a rapid course, and extends to the general peritoneum without the intervention of appreciable local changes.

5. The profound prostration and cardiac inhibition characteristic of peritonitis are, in a great measure, incidental (1) to tension of the peritoneum produced by inflammatory products, with a consequent reflex inhibition of the heart, and (2) mechanical interference with the heart's action.

6. Surgical interference is indicated in all severe cases of general peritonitis and in cases of localized suppurative inflammation, or in cases of perityphlitic origin, whether due to foreign bodies or not.

7. There is every indication present for operation, and no logical objection to it. The operation is almost invariably palliative, if not curative.

8. Operation in no sense impairs the chances of recovery. *Per contra*, it enhances them to a great degree.

9. No case should be allowed to die without operation, unless already *in articulo mortis*.

10. It is not necessary to make a large incision, excepting in cases in which perityphlitic abscess is known to exist, which is rarely the case in children. If perityphlitic abscess exist, and is recognized before operation, the incision should be made at the most favorable point, which, in the majority of cases, is the typical line for ligation of the common iliac, as pointed out by Murphy and Lee. In by far the majority of cases in children, a simple median exploratory incision, with flushing of the abdominal cavity, is sufficient.—*Western Med. Reporter.*

A Poisonous Thimble.—Among the numberless causes of blood-poisoning through the skin, one which was lately recorded is worth noting on account of its evident simplicity and the ease of its prevention. In the case referred to the sufferer was a seamstress, and the mischief resulted from her using a dirty metal thimble marked with verdigris, a little of which appears to have entered a scratch on the thimble finger. We can well believe that this accident was not the first of its kind. Verdigris, it is true, is a mere metallic irritant, and not comparable in virulence to most living germs of disease. It is quite enough, notwithstanding, to excite local inflammation, which friction, contact with dyed cloth material, or the entrance of dirt in any form, would quickly convert into a dangerous and general disorder. There is really no excuse for women who trust their fingers in these cheap and worse than useless articles. Steel thimbles are much safer and cost very little. Another variety also in common use is enameled within, and is, if possible, even freer from objection. Let us not forget to add a caution that cuts or scratches on the hand should never be neglected by sewing women so long as dyes continue to be used in cloth manufacture. —*Lancet.*

Brown-Séquard's Extract in Phthisis.—Dr. M. K. Zieniec relates (*Berlin Klin. Wochenschr.*) five cases of phthisis treated with Brown Séquard's extract, injected subcutaneously. He was led to give this method a trial by the statements of certain writers, to the effect that they had employed the testicular extract in phthisis with good results. Dr. Zieniec made use of dog's testicles, on the presumption that it was advisable to select for this purpose an animal but slightly disposed to phthisis, and because the dog was the commonest example of the kind. The amount of emulsion injected was that contained in a Pravaz syringe; sometimes double this amount was given for a dose. Three of the patients were in an advanced stage of the disease; in the other two it was more recent though well marked. The first two cases received each five injections, each consisting of one syringeful of fluid administered at intervals of a day or two. After injection a slight rise of temperature was observed. In the first case increase in fullness of the pulse was observed, and in both cases sleep improved, the cough diminished in severity, and the general condition became better. The patients, however, ere long relapsed into their former condition. The third patient also received five injections at intervals of a day or two; on the last occasion twice the ordinary amount (one syringeful) was given. In this case, besides an evident improvement in the general condition—diminution of cough and, in consequence, undisturbed sleep—it was observed that the muscular power of the right hand had much increased. But, although the increase was marked after the first injection, after the following injections it was but slight; in fact, the nervo-muscular apparatus appeared to have been stimulated in the manner described by Brown-Séquard. No permanent benefit accrued in this case. In the fourth case similar observations were made in regard to sleep and cough; the pulse also was stronger, and the heart sounds were stronger and clearer after injection. This, however, was accompanied by fever, as a result of which a loss of weight was noticed. The fifth patient received ten injections; apart from improvement in sleep nothing noteworthy was observed, except that no rise of temperature followed injection. The author refrained from a more extensive investigation, seeing no further interest in the subject.—*Brit. Med. Jour.*

Dr. Paul Gibier, Director of the New York Pasteur Institute, makes the following report of the results of the preventive inoculations against hydrophobia performed at his Institute during the first six months of the second year of its existence (February 18, 1891, to August 18, 1891). During this time 415 persons having been bitten by dogs, cats, and other animals applied for treatment. These patients may be divided in two categories:

1. In the case of 345 of these persons it was demonstrated that the animals attacking them were not mad. Consequently the patients were sent back after having had their wounds attended to during the proper length of time.

2. In 70 cases the anti-hydrophobic treatment was applied; hydrophobia of the animals inflicting bites having been evidenced clinically, or by inoculation at the laboratory, and, in many cases, by the death of some other persons or animals bitten by the same dogs.

Indigents have been treated free of charge.

The persons treated were:

17	from New York.	1	from North Carolina.
16	" New Jersey.	1	" Michigan.
11	" Massachusetts.	1	" Pennsylvania.
5	" South Carolina.	1	" Rhode Island.
5	" Texas.	1	" Arkansas.
3	" Connecticut.	1	" Virginia.
2	" Maryland.	1	" Mexico.
2	" Missouri.	1	" West Indies (Curagoa).
1	" Ohio.		

Deaths by Hydrophobia After Treatment.—Miram Adams, five years old, of South Framingham, Mass. Badly bitten July 14 last, in nineteen places by a dog recognized to be mad. Treated from July 15 to August 1. Symptoms of hydrophobia appeared six days later (August 6). Died August 9.

Three other persons (two sisters of the patient) and a man, bitten by the same dog, who received the same course of treatment, are now enjoying good health.

This, so far, is the only death by hydrophobia out of the 255 cases treated at this Institute to date.

Posticus Paralysis in Infants.—From the character of the laryngeal symptoms in these cases, bilateral impairment of the postici muscles suggests itself.

The power to cough, the comparatively clear voice retained, the length of time over which the disease

extends, and the deepening of symptoms as that goes on, differentiates the condition from affections of the abductors—for example, spasm of the glottis. These same qualities equally disprove the existence of papillomata in any of the cases referred to this condition; for in papillomata it is recognized that there is very frequently alteration of voice. In none of the cases was there noticed evidence of cervical or thoracic tumor or any pressure on the vagi or recurrents. Diphtheria was carefully eliminated in each case.

Etiology.—In considering this aspect of the disorder, reference must be drawn to the generally associated diseased states of the post-nasum and pharynx, and the age of the cases at which it is most exclusively met with. Looking at the pronounced symptoms in this condition, it would seem that the only probable explanation of the phenomena is to suppose a bilateral adductor paralysis, and that the subsequent gradually increasing severity of the symptoms where the condition has been in existence for some time is to be attributed to "secondary contracture" of the adductors—a common enough phenomenon in nervous pathology.

Irritation in the regions of the post-nasum, pharynx, etc., is probably transmitted to the medulla, there exciting and exhausting the accessory nucleus, and thus leading to depraved innervation of the muscles in question.

Collateral catarrh of the mucosa covering the postici muscles may also act injuriously on these structures.

Treatment.—From the foregoing indications, treatment on the proper lines must be rigorously carried out, in order that the child may be rescued before secondary contraction sets in, which demands more serious steps to be taken. In the earlier cases met with, I usually prescribed ammonium bromide, tepid sponging, etc., but of late I have treated more rigorously the post-nasal and pharyngeal conditions, and with the best results. Where granulations are felt in the post-nasum, these are crushed or otherwise destroyed. In a severe case, I should at once intubate; because, apart from the relief to respiration for the time being, the insertion of the tube seems to have a rousing effect on the general musculature of the larynx. It seems to dissipate any secondary contraction that may have supervened during the course of the malady, if this has existed long enough to allow of secondary contracture of the constrictors to have taken place.—Robertson, in *The Satellite.*

PRELIMINARY DRILL FOR LARYNGOSCOPY.—Apart from the unwillingness of the patient there is often an utter inaptitude to understand what the doctor requires. To many people it is most difficult to inspire and expire or phonate to order. In such cases I often find that much time is saved by a little patient instruction in carrying out the instructions,—"breathe gently in and out," "say hah!" "draw breath." This having been overcome, the larynx may be seen for a moment—and I must reiterate the well-worn statement that the early laryngoscopic examination should be of the briefest possible duration, though repeated several times. In point of fact, it is a good rule on the first introduction of the mirror merely to insert it for a moment into the back of the mouth, and then to remove it without having necessarily made any serious attempt to see the larynx, but *on no account to appear to the patient disappointed at not having done so.* The examination can usually be accomplished easily and confidently on a second introduction.

We find in the "Rules" that the examination of the interior of the larynx is much facilitated by the patient uttering a note in the "falsetto" (*sit venia verbo!*) "head," or "thin" register. Now the difficulty is to get an untutored patient to do this. Vocalists do it without difficulty, and many adaptable patients can do it by imitation. There is no question in my mind that the power of communicating this accomplishment to the patient is of unspeakable value to the laryngoscopist, and well worth the trouble of acquiring. If the patient can be got to utter the sound "heh" to a head-note, the knot of the difficulty is generally cut. This sound is not familiar to the English throat; it is like the vowel of the word "hell" long-draw out, the "meh" of the sheep, the "ê" of the French "*bête*", or the Scotch exclamation of surprise "Eh!" During the utterance of this sound the larynx is raised into a more favorable position for inspection than when the vowel "ah" is produced, and the mouth is not closed to such an extent as during the emission of the sounds "ay" or "ee." I should advise those "who have not had the advantage of being born north of the Tweed" to acquire the art of pronouncing this vowel.

This being pre-supposed, it remains to get the note uttered on the "head" ("thin") register, and this is really the *crux* of the "preliminary drill." Those who cannot hit off a falsetto note at once may succeed if they commence singing a scale as softly as possible. At a certain stage they will notice the character of the tones alter, and the sense of effort at production becomes less. They will find themselves using the "thin" register. One method then is to make the patient sing the vowel "eh" very softly up the scale, and when he has reached the "thin" register to make him halt, sing several times the note required, and, finally, to emit it "with a will" when the mirror is introduced.

There is yet another method of "dodging" a patient into the use of the "head voice." Patients who are insusceptible to musical methods may succeed in producing a head-note by imitating a little girl calling to her kitten, "Puss, puss, puss" on a very high-pitched note. Others may pick up the comic singer's method of testing his head-register by trying to reproduce the voice of an irate woman, shouting "Eliza-ah!" the last syllable being pronounced on a high falsetto note. The grotesque effect of this proceeding is very "catchy" and often overcomes the difficulty, the transition to the sound "eh" being easy when once the patient has caught the idea.

I may be met finally with the objection that in cases of destruction of the vocal cords and other conditions the productions of the sounds described may be impossible. The reply to this is that it is not so much the actual production of the sound as the attempt to do so that is required.

To those whose earlier or isolated attempts at laryngoscopy have been attended with difficulty, I offer these suggestions with the sympathy and best wishes of a somewhat "old hand." To those "heaven-born" laryngoscopists who have never experienced any difficulty, I offer my humble and admiring congratulations.—Dundas Grant, *Jour. Laryngology.*

POLYCLINIQUE LIBRE DE BRUXELLES, 40, RUE DE RUYSBROECK.—Les cliniques spéciales inaugurées dans le courant de l'été 1891 seront reprises le mercredi, 4 Novembre prochain, et continuées les mercredi et samedi de chaque semaine.

Ces cours, *essentiellement pratiques*, permettent aux praticiens l'étude ou la revision rapide de différentes branches de la médecine.

Ils auront une durée de deux mois et demi, et seront repris trois fois par an: en Novembre, en Janvier et en Avril.

On est prié de se faire inscrire à la Polyclinique tous les jours, de 9 à 10 heures, ou par correspondance.

PROGRAMME DES COURS DU TRIMESTRE D'HIVER (1891).

Mercredi:	Samedi:
9 à 10.—Chirurgie infantile. Orthoédie. Dr. Hendrix.	9 à 10.—Opérations gynécologiques (à l'Institut gynécologique. 12, rue Puits-St-Guidon, à Anderlecht). Dr. C. Jacobs.
10 à 11.—Maladies de l'oreille, du nez, de la gorge. Dr. Hicguet.	11 à 12.—Maladies nerveuses. Électrothérapie. Dr. Glorieux.
11 à 12.—Démonstrations microscopiques et diagnostic d'anatomie pathologique spéciale (maladies des femmes). Drs. Popelin et Cittadini (assistants.)	2 à 4.—Maladies de la peau. Dr. Dubois-Havenith, agrégé, à la Faculté.
2 à 4. —Maladies des femmes. Dr. C. Jacobs, agrégé à la Faculté.	4 à 5.—Maladies des voies urinaires. Endoscopie. Cystocopie. Dr. J. Verhoogen.

FRENCH NOTES.

A. E. ROUSSEL, M.D.

TREATMENT OF SYPHILIS—DANGERS AND INCONVENIENCES OF MERCURY.—In a clinical lecture delivered at the St. Louis Hospital, Dr. Fournier recalls the fact that the treatment of syphilis comprises the three following indications:

1. The administration of specifics to the poison.
2. Auxilliary medications destined to combat the pathological conditions, anæmia, scrofula, rheumatism.
3. An appropriate hygiene.

Notwithstanding that the first of these indications is very important, the others should not be neglected. Apropos of the employment of specifics, Professor Fournier propounds this question: Is mercury, even when given in therapeutic doses, always inoffensive? No; mercury may be dangerous, and its ontoward effects may be ranged under four heads: ptyalism, eruptive effects, gastro-intestinal troubles, nutritive troubles.

In order to avoid stomatitis, we must evidently not exceed certain doses. The special means to avoid salivation are four in number:

1. Examine the mouth before the treatment, and, if necessary, have the patient submit to the dentist's care.
2. Carefully watch the condition of the mouth, and minutely inspect the retro-molar regions. Severe buccal hygiene, cleanliness of teeth, gargarisms.
3. Warn the patient of the possibility of buccal irritation by the mercury, in order that he may arrest the treatment in time.
4. Suspend the treatment at the first alarm.

Mercurial eruptions consist particularly of an erythema, produced by the usage of pomades, more rarely by internal treatment. They are excessively rare and are generally accidents of idiosyncrasy. To avoid the gastric and intestinal troubles, we must vary the preparations, proportion the doses according to the tolerance of the patients, and associate opium with the mercury to insure tolerance. We should not exceed five or six weeks of treatment. If we have to deal with stomachs that absolutely refuse to support the medicament, we will have recourse to inunctions.

The nutritive troubles are much more serious. Mercury determines chloro-anæmia or marasmus under two circustances:

1. When administered in too large doses, in a manner to fatigue the digestive tube, and to cause diarrhœa.
2. When administered for too prolonged a period.

The treatment should often be interrupted. But these accidents are the exception. When the mercurial treatment is well directed the patient experiences marked benefit. The blood globules increase in number, as demonstrated by Hayem, Keys; the patients increase in weight; certain dyspepsias improve, probably as the result of the anti-fermentative action of the mercury. If, therefore, the employment of mercury offers certain dangers, they are easy to avoid by following the rules which have been formulated.

—*Revue de Therapeutique.*

LESIONS OF THE HEART IN INTERMITTENT FEVER (Dr. Sicard).—In the first degree the patients complain at the end of an excess of fever, of palpitations, dyspnœa, of divers malaises, with a sensation of thoracic constriction. Notwithstanding the frequency and inequality of the cardiac pulsations, we do not find any abnormal sounds.

The second degree is characterized by a permanent dyspnœa, weakness, thoracic constriction, attacks of palpitation and acute pain in the cardiac region. The sounds are greatly accentuated, but there is no murmur; there is occasionally noticed a thrill on palpitation.

The third degree is noted by the apparition of an organic affection which consists either in a simple hypertrophy without valvular lesions, or of a valvular lesion without hypertrophy. In the latter case we have an aortic narrowing of an insufficiency of the auricular and ventricular valves.

Of fifty-seven observations collected by Ranzier in a single year, he noted these cardiac symptoms in seventeen cases.—*Revue de Therapeutique.*

TREATMENT OF TUBERCULOSIS BY SUBCUTANEOUS INJECTIONS OF ARISTOL (Nadaud).—The author having successfully employed aristol as a dressing for a tuberculosis wound, determined to utilize it in the form of subcutaneous injections. The form is as follows:

℞.—Aristol.....	1 c. c.
Oil of sweet almonds (sterilized).....	100.

Dose.—One cubic centimeter a day by subcutaneous injection.

Twenty-three patients were treated exclusively by this method. In seven cases the amelioration was such that the patients may be considered as cured. Duration of treatment twenty-five to thirty days. No accidents occurred.—*La Médicine Moderne.*

RECTAL INJECTIONS OF MINERAL WATER IN CHRONIC DIARRHŒA (Polaczek).—The author uses for this purpose Carlsbad water (32° to 42° C.) which he injects into the rectum in amounts of 200 to 250 grammes, at first once, and afterwards twice daily. Chronic diarrhœa is rapidly cured by this treatment.

THE TREATMENT OF CRAMPS OF THE LEGS IN PREGNANT WOMEN.—Administer at bedtime five milligrammes of sulphate of copper. This can be administered every night without inconvenience.—*La Gazette Médicale.*

TREATMENT OF INCONTINENCE OF URINE IN THE FEMALE.—Saenger recommends a sort of massage of the urethra and sphincter with an aseptic female sound. Once introduced we move it in a downward direction; then toward the sides in such a way as to encounter the elastic resistance of the muscular fibers. We thus produce a sort of dilatation, but we should be careful not to overcome the sphincter but only to excite it to action. It is, therefore, a massage rather than a dilatation.—*Gazette de Gynécologie.*

SUDDEN DEATHS: THE MOST FREQUENT CAUSES.—We are always astonished to notice how frequently physicians called upon to sign a death certificate in cases of sudden decease give as a cause, *foudroyante apoplexy, rupture of an aneurism.*

Cerebral apoplexy rarely causes sudden death and aneurisms only in the proportion of 5 per hundred, as proved by the statistics of Wynn Westcott, of London.

Of one thousand inquests noted by him, if we eliminate deaths caused by accidents, murders and suicides, and those of children under twelve years of age, there remains three hundred and three cases of sudden death. One hundred and eighty-five among the male sex and one hundred and eighteen among females. In one-third of the cases sudden death should be attributed to alcoholic excesses.

Westcott divides the causes into three classes:

1. The *syncopes*, 210 cases—15 ruptures of aortic aneurisms, 4 ruptures of the heart, 20 cases of valvular lesions of the heart, 3 cases of cardiac dilatation, 77 fatty degeneration of the heart, 10 hemoptysis, 3 hematemeses, 2 metorrhagia, 2 emboli, 3 perforations of the stomach or of the intestine, 2 cases of angina pectoris, 3 of *delirium tremens*, etc.

2. *Coma* 64—of which 20 were due to alcohol.

3. *Asphyxia* 29—œdema of the glottis, croup, convulsions, etc.—*La Médicine Moderne.*

Medical News and Miscellany.

DR. S. DICKSON BARR has removed to 1419 Walnut street, Philadelphia.

DR. T. D. MYERS has removed his office to his residence, 1703 Locust street, Philadelphia.

DR. A. E. FROOM, of Chicago, was fined $25 for failing to report a diphtheria case on Wentworth avenue.

Emperor William has appointed Prof. Helmholtz, the eminent physiologist, a member of the privy council.

WANTED.—Copies of THE TIMES AND REGISTER for September 27 and November 22, 1890, and January 17 and February 28, 1891. A liberal price will be paid.

DR. JOHN E. OWEN, the Medical Director of the Columbian Exposition, has promised the President of the Board of Lady Managers that women shall receive official recognition upon his staff.

JUDGE B. K. HIGGINBOTHAM, of Frankfort, Ind., died very suddenly, on the morning of the 19th inst., at Plainfield. While the telegram announcing his death gave no particulars, it is supposed that it was due to his physical inability to stand the bichloride of gold treatment of the Keeley Institute, in which he had placed himself for a cure of the drink habit.
—*Chicago Daily News.*

IT is said that Mr. Murphy, the United States Special Agent, is meeting with considerable success in his efforts to introduce corn into Germany. If the corn were to be liquefied, it would flow more readily into the new channels.

DR. EDWARD BEDLOE, United States Consul at Amoy, China, who has been an active promoter of the interests of the World's Fair, writes to Chief Handy that, in all English-speaking circles in China, there is a great and growing interest in the Chicago Exposition. In addition to other work, he has secured promises from eight friends to send on their private collections of curios and bric-a-brac in 1893, and hopes to obtain most interesting collections from Amoy and from Formosa.

A CORRESPONDENT of the Washington *Star*, who has been studying the subject of getting rid of fleas, gives this as the result of his investigations: If those who are troubled with this insect will place the common adhesive fly-paper on the floors of the rooms infested, with a small piece of fresh meat in the center of each sheet, they will find that the fleas will jump toward the meat and adhere to the paper. I completely rid a badly infested house in two nights by this means.

DR. L. WEBSTER FOX is of opinion that savage races possess the perception of color to a greater degree than do civilized races. After examining 100 Indian boys, Dr. Fox found no case of color blindness. In the same number of white boys at least 5 cases would have been discovered. Some years ago 250 Indian boys were examined, and only 2 cases of color blindness were met with, a very low percentage when compared with the whites. Among the Indian girls he did not find any. Among whites 2 females in every 1,000 are color blind.

THE Pennsylvania company has a large corps of surgeons in its employ, constantly ready with their services in case of accident on the road, and on October 20, about twenty-five of them held their ninth annual meeting at the Grand Pacific Hotel, Chicago. Officers were elected as follows: J. J. Buchanan, of Pittsburg, President; Dr. Foster, Washington, Vice-President, and S. B. Post, Canton, Ohio, Secretary and Treasurer. The following were selected as an executive committee: A. W. Ridenour, Massillon, Ohio; J. B. Murdock, Pittsburg, and J. J. Larkin, South Chicago. Half a dozen papers of improved methods in surgery were read.

POLYCLINIC EVENING LECTURES.—The Faculty of the Philadelphia Polyclinic delivers two evening lectures a week, at 8 o'clock, during the course of 1891–92. The following lectures are announced:

October 27. Dr. C. K. Mills, "Aphasias, and How to Study and Treat Them."

October 30. Dr. G. Betton Massey, "Some Everyday Experiences in Electro-gynecology."

November 3. Dr. Edward Jackson, "Shadow Test."

November 6. Dr. B. F. Baer, "A Plea for Early Diagnosis."

November 10. Dr. Edward Jackson, "Shadow Test."

November 13. Dr. B. F. Baer, "The Treatment of Retro-displacements."

November 17. Dr. T. S. K. Morton, "Appendicitis."

November 20. Dr. R. W. Seiss, "Treatment of Aural Pain."

VAN HOUTEN & ZOON, the manufacturers of cocoa at Weesp, Holland, have set apart $100,000 with which to make a splendid exhibit at the Exposition in Chicago, in 1893. They intend to erect a large building in the style of old Holland architecture of the fifteenth century, and to put in it, besides an exhibit in their own line of business, paintings, views, bric-a-brac, etc., illustrative of the Netherlands, and the life and characteristics of the Dutch people. They will have there a "cocoa school," where Dutch maidens, clad in picturesque native attire, will make delicious cocoa beverages according to the most approved methods, and will serve it to visitors.

WEEKLY Report of Interments in Philadelphia, from October 17 to October 24, 1891:

CAUSES OF DEATH.	Adults.	Minors.	CAUSES OF DEATH.	Adults.	Minors.
Abscess	1	1	Fever, typhoid	3	1
Anæmia	1	2	Homicide	1	
Apoplexy	9		Inanition		8
Asthma	2		Inflammation bladder	1	
Aneurism of the aorta	1		" brain	6	5
Bright's disease	11	1	" bronchi	3	4
Burns and scalds		2	" kidneys	5	
Cancer	19		" larynx	1	2
Casualties	5	3	" liver	2	
Congestion of the brain	1	4	" lungs	8	6
" " lungs	2		" heart		1
Congestive chill	1		" peritoneum	4	
Chorea		2	" s. & bowels	4	6
Cholera infantum		16	Locomotor ataxia	1	
Cirrhosis of the liver	5		Malformation		1
Collapse of lungs	1	1	Marasmus	1	16
Consumption of the lungs	50	6	Measles		1
" " bowels		1	Neuralgia of the heart	1	
Convulsions		9	Old age	11	
" puerperal	1		Paralysis	5	
Caries of spine		1	Rheumatism	1	
Croup		11	Shock		1
Cyanosis		1	Sclerosis	1	
Debility	3	2	Scrofula		1
Diabetes	3		Septicæmia	1	
Diarrhœa	2		Sore mouth		1
Diphtheria		37	Softening of the brain	1	
Disease of the heart	25	7	Suffocation		1
" " kidneys	2		Suicide	4	
Drowned	1		Tabes Mesenterica		2
Dropsy of the brain		1	Tetanus		1
Dysentery	2		Tumor	1	
Erysipelas		2	Ulceration of the bowels	2	
Enlargement of the heart	2		Uræmia	8	
Fatty degeneration of the heart	4		Whooping cough		1
Fever, malarial		3	Total	230	177
" scarlet		5			

ELECTRICITY IN HYDROCELE.—A. C. S. has been suffering from a very large left hydrocele for two years. He says that he had, first, orchitis, and subsequently the fluid gradually accumulated in the sac. The fluid, about a pint, was drawn off by an ordinary hydrocele trocar and canula; and when the sac was empty, an insulated platinum probe attached to the negative pole of the battery was passed through the canula and freely applied to nearly the whole of the inner surface of the sac with a current of about 4 milliamperes for about three minutes, the positive pole being placed over the left groin. There was some smarting pain, and a little sanious discharge through the canula during the operation. The patient had slight fever and swelling of the scrotum on the third day; the fever completely subsided after three days, but the swelling took about a month to disappear. The operation was performed on the 14th of February, and when he left the station, on the 10th of April, he was completely cured of the hydrocele, and the left testis, which was a little larger than the right one, was also reduced to normal size. Four other cases have been treated according to the above method, and three of them turned out successful.

—Nundo Hall Ghose, in *Indian Med. Gazette.*

THE HOSPITALS OF PHILADELPHIA.

CHILDREN'S HOSPITAL.

LOCATION: 207 South Twenty-second street. Age: Thirty-five years. Patients received: Acute and chronic cases, children only. Patients not received: Contagious cases. Terms per week: Free. Actual cost per week per patient: $6. Visiting hours: Monday and Thursday, 2 to 4.30 P. M. Resident physicians: Male, 2; female, none; how appointed, by examination; term of service, twelve months; pay, none. Nurses: Male, none; female, 10; pay, $15 per month; term of service, permanent; training school, no; kind of nursing taught, nursing of children; diploma or certificate awarded, none. No special facilities for massage, electricity, or hydrotherapy. Clinics: Kind, medical and surgical; number, 2 per week; day, Wednesday; hours, 10 A. M. to 12 M.; duration, October 1 to March 1. Instruction for students: Clinics, as stated; ward classes, none; terms, free. Maternity cases not taken. Dispensary work: Charge, nominal for medicine; departments, medical, 11 A. M. to 12 M., and 4 to 5.30 P. M.—surgical, 11 A. M. to 12.30 P. M., Tuesday and Friday, 11 A. M.—eye, Tuesday, Thursday, and Saturday, 2 P. M.; average number of patients, 1,000 per month; average number of prescriptions, about 1,500. Names of physicians of hospital.—Dispensary physicians and surgeons: Drs. Morris J. Lewis, Walter D. Green, J. Madison Taylor, Charles Wirgman, W. E. Hughes, D. J. M. Miller, John Gillespie, Jr., Edward Martin, T. Hewson Bradford, G. G. Davis, W. Zentmayer, J. P. Crozer Griffith. Remarks: Hospital has one ambulance, a special ward for tracheotomy, and a convalescent branch in the country.

CHILDREN'S HOMŒOPATHIC HOSPITAL.

Location: 914 North Broad street. Age: Fourteen years. Number of beds, 50; wards, 3. Patients received: Acute cases, chronic cases with acute symptoms, under twenty-one years of age. Patients not received: Contagious and venereal cases, and alcoholism. Terms per week: $1 to $3 (mostly charitable). Beds all free. Visiting hours: Tuesday and Friday, 2 to 5 P. M. Resident physicians: Male, 2; female, none; how appointed, by examination; term of service, one year; pay, $50 for junior, $100 for senior. Nurses: Male, none; female, 3; term of service, permanent; training school, no; kind of nursing taught, children; diploma or certificate awarded, none. No special facilities for massage, electricity, or hydrotherapy. No clinics. No instruction for students. Maternity cases not taken. Dispensary work: Charge, free; departments, medical and surgical, daily, 11 A. M.—gynecological, Tuesday, 11 A. M.—dental, Monday, 11 A. M.—skin, Tuesday and Friday, 11 A. M.—ear, nose, and throat, Monday, Wednesday, and Saturday, 11 A. M.—eye, Tuesday and Friday, 2 P. M.; average number of patients, 1,000 (visits); average number of prescriptions, about 1,200. Names of physicians of hospital.—Medical Board: Bushrod W. James, M.D., President; J. W. Giles, M.D., Vice-President; Landreth W. Thompson, M.D., Secretary; Drs. J. R. Earhart, Jacob Frishmuth, Joseph M. Reeves, J. C. Millen, George W. Gardiner, Wm. S. Morris, James H. Closson, E. R. Snader, Frederic W. Messerve, Albert A. Norris, John D. Ward, E. L. Oatley; Consulting Staff: Drs. James Kitchen, C. Neidhard, T. C.

Williams, Aug. Korndœrfer, Mahlon M. Walker; Consulting Surgeons: Drs. John E. James, Charles M. Thomas; Consulting Gynecologist: B. Frank Betts, M.D.; Externe Physicians: Drs. Theodore P. Gittens, Robert S. Summers; Matron: Mrs. M. R. Barber. Out-patient Department and Polyclinic.—Surgeons: Drs. J. W. Giles, Frederic W. Messerve; Diseases of the Ear, Throat, and Nose: Wm. S. Morris, M.D.; Diseases of the Eye: Bushrod W. James, M.D.; Diseases of the Skin: Albert A. Norris, M.D.; Diseases of Women: Joseph M. Reeves, M.D.; Diseases of Heart and Lungs, E. R. Snader, M.D.; Diseases of the Nervous System: John D. Ward, M.D.; Pathologist: E. L. Oatley, M.D.; Dental Clinic: F. Morton Long, M.D., D.D.S. Remarks: Hospital has ambulance, and isolation ward.

GERMANTOWN HOSPITAL AND DISPENSARY.

Location: Penn and Chew streets, Germantown. Age: Hospital, twelve years; dispensary, twenty-seven years. Number of beds, 50; wards, 2, and 5 special. Patients received: Acute cases, chronic cases occasionally, adults and children. Patients not received: Contagious and venereal cases, alcoholism. Terms per week: Free. Actual cost per week per patient: $12 50. Visiting hours: Monday, Wednesday, and Friday, 4 to 5 P. M. Resident physicians: Male, 2; female, none; how appointed, by election; term of service, one year; pay, none. Nurses: Male, 2; female, 5; training school starting; kind of nursing taught, general. No special facilities for massage, electricity, or hydrotherapy. No instruction for students. Maternity cases not taken (treated at home). Dispensary work: Charge, free; departments, medical, surgical, and gynecological, Monday, Wednesday, Thursday, and Friday, 10 A. M. to 12 M.—eye, Tuesday and Saturday, 10 A. M. to 12 M.—ear, nose, and throat, Tuesday and Saturday, 3.30 to 5 P. M.; average number of patients, 400 (visits), 198 (new) per month. Names of physicians of hospital.—Attending Physicians: Drs. Auguste F. Müller, Edw. F. Garrett, R. W. Deaver, Chas. A. Currie; Eye Department: Drs. George T. Lewis, L. Webster Fox; Throat, Nose, and Ear: S. MacCuen Smith, M.D.; Consulting Surgeons: Drs. D. Hayes Agnew, William Hunt; Consulting Physicians: Drs. James Darrach, William R. Dunton. Remarks: Acute cases admitted at all hours, others at 12 M.; hospital has ambulance, isolation ward, and is constructed upon the pavilion plan; supported by voluntary subscriptions only.

GYNECEAN HOSPITAL.

Location: 247 North Eighteenth street. Age: Three years. Number of beds, 40. Patients received: Acute and chronic cases, adults (only gynecological cases received). Patients not received: Contagious and venereal cases, alcoholism. Terms per week: A small sum if patient is able. Visiting hours: daily, 3 to 5 P. M. Nurses: Female, 5; pay, $10 per month (first month probation); term of service, one year; training school, yes; kind of nursing taught, gynecology; diploma or certificate awarded, diploma. Maternity cases not taken. Dispensary work: Charge, none (medicine free). Average number of patients: 25 to 30 per week. Names of physicians of hospital.—Attending Surgeons: D. Hayes Agnew, M.D., LL.D., Charles Kingham Penrose, M.D.; Consulting Physician: J. M. Da Costa, M.D.; Pathologist: Morris Longstreth, M.D.; Drs. W. D. Green, J. B. Shober, A. C. Wood, Martin Downs.

EPISCOPAL HOSPITAL.[1]

Location: Front and Lehigh avenue. Age: Forty years. Number of beds, 200; wards, 6. Patients received: Acute, chronic, and venereal cases, adults and children. Patients not received: Contagious cases. Terms per week: $7. Actual cost per week per patient: $7 25. Beds all free. Visiting hours: Daily (except Sunday), 2 to 3 P. M. Resident physicians: Male, 6; female, none; how appointed, elected by managers; term of service, eighteen months; pay, none. Nurses: Male, 8; pay, $10 to $25 per month; term of service, two years; training school, yes; kind of nursing taught, general and special; diploma or certificate awarded, yes. Facilities for massage, none; electricity, yes; hydrotherapy, limited. No clinics. No instruction for students. Maternity cases not taken. Dispensary work: Average number of patients, 1,663 per month (new cases); average number of prescriptions, 6,180 per month. Names of physicians of hospital.—Physicians: Drs. James M. Anders, D. J. Milton Miller, Caspar Morris, Henry M. Fisher; Surgeons: Drs. Thos. R. Neilson, J. H. C. Simes, Richard H. Harte, Wm. B. Hopkins; Ophthalmic and Aural Surgeons: Drs. Albert G. Heyl, G. Oram Ring. Dispensary Staff.—Physicians: Drs. Elliston J. Morris, A. K. Minich, Frederick A. Packard, B. B. Reath, Jr.; Surgeons: Drs. A. Hewson, G. G. Davis, H. C. Deaver, George M. Boyd.

GERMAN HOSPITAL.

Location: Corner Girard and Corinthian avenues. Age: Thirty-one years. Number of beds, 160; wards, 12, and 30 smaller rooms. Patients received: Acute cases, chronic cases under conditions and for limited periods, adults. Patients not received: Contagious and venereal cases, alcoholism. Terms per week: $6 (private rooms extra). Visiting hours: Tuesday and Thursday, 3 to 4 P. M. Resident physicians: Male, 3; female, none; how appointed, by examination; term of service, one year; pay, none. Nurses: Male, 10; female, 30; pay, males only (female nurses are voluntary Protestant deaconesses); training school, yes; kind of nursing taught, general and special; diploma or certificate awarded, none. Special facilities for massage, electricity, and hydrotherapy. Clinics: Medical, Tuesday and Friday, 11 A. M. to 1 P. M.—Surgical, Monday, Wednesday, and Saturday, 10 A. M. to 1 P. M.—gynecological, Wednesday and Saturday, 2 to 4 P. M.—eye, ear, nose, and throat, Tuesday and Friday, 2 to 4 P. M. Instruction for students: Clinics, as stated; ward classes, none; terms, free. Maternity cases not taken. Dispensary work: as stated under "Clinics." Names of physicians of hospital.—Physicians: Drs. A. Frau, L. Wolff, J. C. Wilson; Surgeons: Drs. J. B. Deaver, J. W. White, C. B. Penrose (all voluntary); Chief Resident: C. Frese (paid). Remarks: Hospital has two ambulances, special dead-house, disinfecting-house, and is lighted by electricity; patients are admitted from 9 A. M. to 12 M.—emergency cases any time; about one-half of the patients are free.

HOWARD HOSPITAL.

Location: 801 South Broad street. Age: Thirty-six years. Number of beds, 13. Patients received: Acute cases, (department for incurables not in operation), adults and children. Patients not received: Contagious cases. Terms per week: Free. Visiting hours: Daily, 3 to 5 P. M. Resident physicians: Male, 2; female, none; how appointed, by examination; term of service, one year; pay, none.

[1] The hospital of the Protestant Episcopal Church.

Nurses: Male, none; female, 4; pay, nominal; term of service, one year; training school, yes; kind of nursing taught, general and special; diploma or certificate awarded, yes. No special facilities for massage, electricity, or hydrotherapy. Clinics: (see "Dispensary Work"). Maternity cases: At what time taken, two weeks before labor (also attended at homes); terms, free. Dispensary work: Charge, each prescription 5 cents; departments, medical, daily, 11 A. M. to 12.30 P. M.—surgical, daily, 10 to 11 A. M.—gynecological, daily, 11 A. M. to 12 M.—skin, Monday, Wednesday, and Friday, 12.30 to 1.30 P. M. —children, 9 A. M.—nervous, Tuesday and Friday, 11 A. M. to 12 M.—eye, Tuesday, Thursday, and Saturday, 2 P. M.—throat, ear, and nose, Tuesday, Thursday, and Saturday, 11 A. M. to 12 M. Names of physicians of hospital.—Medical Board, General Surgery and Orthopædics: Drs. George McClellan, Edward Martin; General Medicine: Drs. John W. Barr, Charles Wirgman, Frederick M. Luther, J. P. Crozer Griffith; Diseases of Women: Drs. Henry Morris, Robert H. Hamill, T. Hewson Bradford, G. Betton Massey; Diseases of Children: Drs. William B. Atkinson, John M. Keating; Diseases of the Mind and Nervous System: Drs. Lewis Brinton, J. Madison Taylor; Diseases of the Eye: Drs. Franklin D. Castle, C. Jay Seltzer; Diseases of the Throat, Ear, and Nose: Drs. O. H. Koons, E. L. Vansant; Diseases of the Skin: Drs. H. W. Stelwagon, Arthur Van Harlingen.

HAHNEMANN HOSPITAL.

Location: Fifteenth street, above Race. Number of beds, 150. Patients received: Acute, chronic, and venereal cases, alcoholism, adults and children. Patients not received: Contagious cases. Terms per week: $7. Number of free beds: 78. No special visiting hours. Resident physicians: Male, 4; female, none; how appointed, by examination; term of service, one year; pay, none. Nurses: Male, 2; female, 26; pay, $10 per month; term of service, two years; training school, yes; kind of nursing taught, general and special; diploma or certificate awarded, diploma. Facilities for massage (special man appointed); hydrotherapy, none. Clinics: Kind, medical, surgical, gynecological, eye, etc.; number, 6 per week; hours, 1 P. M. Instruction for students: Clinics, as stated; ward classes, at intervals; terms (see announcement of college). Maternity cases not taken. Dispensary work: Charges, none; departments, all diseases; hours, daily, 12 M. Remarks: Hospital has ambulance, special isolation ward, and all modern conveniences.

JEFFERSON HOSPITAL.

Location: Sansom street, between Tenth and Eleventh streets. Age: Sixty-seven years. Number of beds, 200. Patients received: Acute and venereal cases, alcoholism, adults and children. Patients not received: Contagious cases. Terms per week: $7 in wards, $25 in rooms. Visiting hours: Daily (except Sunday), 3 to 5 P. M. (private patients any hour). Resident physicians: Male, 5; female, none; how appointed, by examination; term of service, one year; pay, none. Nurses: Male, 8; female, 15; pay, $8 to $25 per month; term of service, two years; training school, yes; kind of nursing taught, general and special; diploma or certificate awarded, yes. Facilities for massage or hydrotherapy, no special; electricity, special. Clinics (see college announcement). Instruction for students (see college announcement). Maternity case: At what time taken, a few weeks before labor. Dispensary work: Charge, small for medicine; departments, orthopædic, Tuesday, Thursday, and Saturday, 12 M.—medical, daily, 11.30 A. M. to 1 P. M.—surgical, daily, 12 M. to 2 P. M.—eye, skin, throat and nose, women and children, daily, 12 M.—nervous, Monday, Wednesday, and Friday, 12 M.—ear, daily, 1 P. M. Names of physicians of hospital.—Dispensary, Medical: Chief, Edwin E. Graham, M.D.; Registrar, A. A. Eshner, M.D.; Assistants, Drs. Thos. G. Ashton, Chas. S. Hearn, C. D. Spivak, Noble B. Parvin, Bayard Murray, J. A. Irwin, E. W. Stevens, Paul Bartholow. Surgical: Chief, Orville Horwitz, M.D.; A. Hewson, M.D.; Assistants, Drs. J. Chalmers Da Costa, Wm. M. L. Coplin, Martin H. Williams, Henry D. Moore, Daniel W. Flemming, I. E. Bennett, Robert B. Judge, Rudolph Kindig, A. F. Tod, Wm. I. Miller, C. A. Veasey, H. J. Fiet. Obstetrical and Gynecological: Chief, E. P. Davis, M.D.; Electrician, J. M. Fisher, M.D.; Assistants, Drs. R. H. Dengler, Ludwig Loeb, E. C. Warg, W. H. Wells, H. D. Hazzard, H. J. Fiet. Ophthalmological: Chief, Howard F. Hansell, M.D.; Assistants, Drs. Thomas O. Nock, Jas. H. Bell, W. S. Powell, C. R. Casperson, Ross R. Bunting. Laryngological: Chief, Louis Jurist, M.D. Otological: Chief, S. MacCuen Smith, M.D.; Assistants, Drs. William S. Jones, G. Hudson Makuen, Jas. Thorington. Orthopædical: Chief, J. P. Mann, M.D.; Assistants, Drs. T. W. Bortree, Robert Casperson. Dermatological: Assistants, Drs. J. Abbott Cantrell, Henry B. Nightingale, John Lindsay. Diseases of Children: J. N. Rhoads, M.D.; Assistants, Drs. Joseph Klapp, W. M. Capp, T. J. Bowes. Renal: Assistant, W. R. Wilson, M.D. Neurological and Electrical: Assistants, Drs. E. S. Lawrence, Burton W. Swayze.

JEWISH HOSPITAL.

Location: York road and Tabor street. Age: sixteen years. Number of beds, 52; wards, 4. Patients received: Acute, chronic, and venereal cases, adults and children. Patients not received: Contagious cases, alcoholism. Terms per week: Free (if able to pay, $5 to $10). Actual cost per week per patient: $7. Number of free beds: All. Visiting hours: Daily, 1 to 4 P. M. Resident physicians: Male, 2; female, none; how appointed, by election; term of service, one year; pay, $80 to $150 per year. Nurses: Male, 4; female, 5; pay, $15 to $25 per month; term of service, optional. No special facilities for massage, electricity, or hydrotherapy. Clinics: Number, 2 daily; hours, 9 A. M. to 4 P. M. No special instruction for students. Names of physicians of hospital. —Drs. T. G. Morton, J. B. Roberts, L. W. Steinbach, Benjamin B. Wilson, O. J. Wister, Thomas Betts, A. Feldstein, S. Solis-Cohen, C. S. Turnbull. Remarks: Hospital has ambulance, and separate kitchen.

KENSINGTON HOSPITAL FOR WOMEN.

Location: 136 Diamond street. Age: Eight years. Number of beds, 21; wards, 3; rooms, 3. Patients received: Acute cases, adults only. Patients not received: Chronic, contagious, and venereal cases, alcoholism. Terms per week: $5 to $25 (also, free beds). Visiting hours: Tuesday and Friday, 2 to 5 P. M. No resident physicians. Nurses: Male, none; female, 3; term of service, one year; training school, yes; kind of nursing taught, gynecological; diploma or certificate awarded, yes. No special facilities for massage, electricity, or hydrotherapy. No clinics. No instruction for students. Maternity cases not

taken. Dispensary work: Departments not yet opened. Names of physicians of hospital.—Drs. Chas. P. Noble, Geo. M. Boyd; Clinical Assistants: Drs. H. H. Applebach, A. H. Deekens.

MATERNITY HOSPITAL.

Location: 734 South Tenth street. Number of beds, 21; wards, 4 delivery, 2 convalescent. Patients not received: Contagious and venereal cases, alcoholism. Terms per week: $3 to $7. No visiting hours. Resident physician: Male, none; female, 1; how appointed, by examination; term of service, one year; pay, none. Nurses: Male, none; female, 4; pay, none; term of service, three to six months; training school, yes; kind of nursing taught, obstetrical; diploma or certificate awarded, yes. No clinics. No instruction for students. Maternity cases: At what time taken, two weeks before labor. No dispensary work. Names of physicians of hospital.—Drs. W. H. Baker, Robert H. Hamill, Barton C. Hirst, Wm. R. Gordell. Remarks: No unmarried women admitted except for first confinement.

MUNICIPAL HOSPITAL FOR INFECTIOUS DISEASES.

Location: Twenty-second street and Lehigh avenue. Age: Twenty-six years. Number of beds, 150; wards, 9; rooms, 3. Patients received: Acute contagious diseases; male, female, and children. Terms per week, $7. No visiting hours. No resident physician at present (appointed by the Board of Health). Nurses: Male, 1; female, 1. Name of physician of hospital.—Wm. M. Welch, M.D. Remarks: Hospital has two ambulances; clothing which is infected is destroyed, or, if disinfected, a small charge is made.

METHODIST EPISCOPAL HOSPITAL.

Location: Broad and Wolf streets. Number of beds, 70 (7 endowed). Hospital is not yet completed.

PHILADELPHIA ORTHOPÆDIC HOSPITAL; INFIRMARY FOR NERVOUS DISEASES.

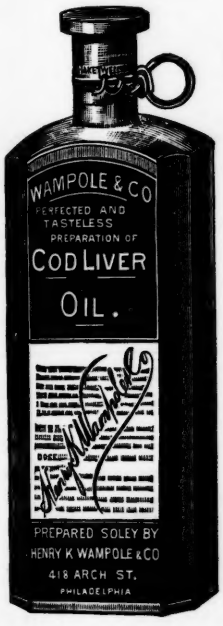
Location: Seventeenth and Summer streets. Age: Twenty-three years. Patients received: Chronic cases, adults, children must be three years old. Patients not received: Contagious cases. Terms per week: $10; rooms, $15 to $35 (washing and medicine extra). Visiting hours: Tuesday, Thursday, and Friday, 2 to 4 P. M. Resident physicians: Male, 2; female, none; how appointed, by election; term of service, one year; pay, none. Nurses: Male, none; female, 15; pay, $5 to $10; term of service, two years; training school, yes; kind of nursing taught, special; diploma or certificate awarded, yes. Facilities for massage, yes; electricity, special. Clinics (see "Dispensary"). Instruction for students: Clinics, yes; terms, free. Maternity cases not taken. Dispensary work: Departments, nervous, Monday, Wednesday, and Friday, 1 P. M.—old cases, Monday, Wednesday, and Friday, 2 P. M.—deformities, Tuesday, Thursday, and Saturday, 1 P. M. Average number of patients, 283 per month (last year). Names of physicians of hospital.—Attending Surgeons: Drs. Thomas G. Morton, H. Earnest Goodman, William W. Keen; Attending Physicians: Drs. S. Weir Mitchell, Wharton Sinkler, Morris J. Lewis: Consultants: Drs. D. Hayes Agnew, George R. Morehouse, William Hunt; Assistant Surgeons: Drs. G. G. Davis, Wm. Johnson Taylor; General Assistant Surgeon: Thomas S. K. Morton, M.D.; Assistant Physicians: Drs. J. Madison Taylor, Guy Hinsdale, John Kearsley Mitchell; General Assistant Physician: Francis X. Dercum, M.D.; Resident Physician: Edgar Strayer, M.D.; Medical Electrician: I. Pearson Willitts, M.D.; Ophthalmologist: George E. de Schweinitz, M.D.; Gynecological Assistant: Barton C. Hirst, M.D.; Registrar: Frederick A. Packard, M.D.; Anæsthetizer: William H. Bricker, M.D. Remarks: Applicants must pay if able, and should apply for admission Monday, Wednesday, and Friday, at 1 P. M., for nervous diseases; Tuesday, Thursday, and Saturday for deformities.

PHILADELPHIA HOSPITAL, PHILADELPHIA ALMSHOUSE.

Location: Thirty-fourth and Spruce streets. Age: One hundred and twenty years. Number of beds, 1,100 (about). Patients received: All diseases except contagious (special department for the insane). Terms per week: Free (if desired to pay, $3.50 per week, about cost). Beds all free. Visiting hours: Tuesday, Thursday, and Saturday, P. M. (permit required). Resident physicians: Male, 20 (2 for insane); how appointed, by examination; term of service, hospital, fifteen months; pay, insane department, $600. Nurses: Female, 100; pay, $9 to $15: term of service, six months to two years; training school, yes; kind of nursing taught, general; diploma or certificate awarded. Facilities for massage and hydrotherapy, none; electricity, special. Clinics: Kind, medical, surgical, and gynecological; number, 6 per week; days, Wednesday and Saturday; hours, 9 A. M. to 12 M. Instruction for students: Clinics, yes; ward classes, yes (conducted by attending physician); terms, free. Maternity cases: At what time taken, third month of pregnancy. No dispensary work. Names of physicians of hospital.—Chief Resident, Daniel E. Hughes, M.D.; Physicians: Drs. R. G. Curtin, James B. Walker, J. H. Musser, F. P. Henry, James Anders, W. E. Hughes, S. Solis-Cohen, Eugene Vansant; Surgeons: Drs. W. G. Porter, L. Steinbach, John B. Darer, Earnest Laplace, W. J. Hearn, A. W. Ransley, Orville Horwitz, James Barton; Obstetricians: Drs. Clara Marshall, E. E. Montgomery, E. P. Davis, Robert H. Hamill, Theophilus Parvin, Barton C. Hirst, W. C. Ashton, George McKelway; Neurologists: Drs. Charles K. Mills, Francis Dercum, Wharton Sinkler, J. Hendrie Lloyd; Ophthalmologists: Drs. George De Schweinitz, George M. Gould; Dermatologists: Drs. H. W. Stelwagon, J. A. Cantrell; Pathologist: Henry E. Formad, M.D.; Bacteriologist: E. O. Shakespeare, M.D.; Assistant Pathologists: Drs. J. L. Hatch, H. W. Cattel; Laryngologists: Drs. C. Jay Seltzer, George Marshall.

[CONCLUDED NEXT WEEK.]

Wampole's Perfected and Tasteless Preparation of Cod-Liver Oil.



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Put up in 5-pint bottles for convenience in dispensing, and as a regular stock bottle. 5-pint bottles, each $3.00, net.

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Notes and Items.

THE TRANSFERRED MALADY (A CASE OF METASTASIS).

(IN AN OCULIST'S OFFICE.)

How sweet the girl! I saw her pass
  The waiting group, with dumb surprise,
A golden-haired, trim, willowy lass,
  With heaven's soft azure in her eyes.
What could there be in them to mend?
  Nothing, I stoutly should insist;
But still she asked to see my friend
  The bachelor—the oculist.

I saw her take the patient's chair
  (Venus and Science matched amain),
And, though his search found little there,
  He asked the girl to come again.
But while with his ophthalmoscope
  He sought the source of her distress,
In the next room, with rhyme and trope,
  I tried my rapture to express.

"Neuritis of mild type it is,"
  He said (whatever that may be);
"Here is a wash I use for this;
  But come each day and visit me."
I knew the doctor's ready skill;
  Yet while he battled with the case,
His eyes received from hers a thrill;
  A crimson flush suffused her face.

Daily, as she was bid, she came;
  Daily the doctor scanned her eyes.
A cardiac spasm, I need not name,
  At length he struggled to disguise;
For gazing in those orbs of blue
  So close transferred an aching smart—
No "wash" he ever gave or knew
  For ailing eyes could help his heart.

The girl was cured, the patient lost.
  What now avails his utmost fees
Or rapid skill, to be so tossed
  About by Cupid's sharp caprice?
Those blue eyes, had *I* the case,
  Should not have been for years dismissed.
To keep them always face to face
  I'd die—a baffled oculist.

—Joel Benton, in *Harper's Monthly.*

CUSTOMER (in Kansas drug store): "I should like a small vial of sporotrichum gobuliferum."

Druggist (in hissing whisper): "Sh-h-h-h! That's old Waters, the prohibitionist, back there by the prescription case. You can't fool him."

Customer: "What do you mean? I merely asked for some of the fungus used to kill chinch bugs."

Druggist: "Oh! I thought you was trying to ask for whiskey in a roundabout way!"

Notice to Advertisers:

The first number of January, 1892, will be a special issue; going to every physician in the following States and Territories:

ARIZONA	69	MISSOURI	5000
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THE MEDICAL PRESS COMPANY, LTD.,
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